[Physician Date]

[Physician Name]
[Clinic/Practice Name]
[Address]
[Phone Number]

RE: Medical Clearance for Bariatric Surgery
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To [Surgeon Name/Surgical Center],

I am writing to provide formal medical clearance for [Patient Name] for their upcoming bariatric surgical procedure ([Procedure Type, e.g., Gastric Sleeve/Bypass]).

[Patient Name] has been under my care for [Duration of Time]. We have reviewed their medical history, including [List Co-morbidities, e.g., Type 2 Diabetes, Hypertension, Sleep Apnea]. Currently, their chronic conditions are [Stable/Optimized] for surgery.

A physical examination and pre-operative evaluation were completed on [Date]. Based on my assessment, I find the patient to be in stable condition and medically cleared for general anesthesia and the planned surgical intervention.

Please find the attached recent lab results and EKG for your records. If you require any additional clinical information, please do not hesitate to contact my office.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Credentials]