Date: [Date]

To: [Surgeon's Name]
[Clinic/Practice Name]
[Address Line 1]
[Address Line 2]

RE: Psychological Clearance for Cosmetic Procedure

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Proposed Procedure: [Name of Procedure]

Dear [Surgeon's Last Name],

I am writing to provide the psychological evaluation results for [Patient Name], who is seeking the aforementioned cosmetic procedure. I conducted a clinical interview and psychological assessment on [Date of Evaluation].

The purpose of this evaluation was to determine the patient's psychological readiness, emotional stability, and expectations regarding the surgical outcome. Based on my findings, the patient demonstrates a clear understanding of the risks and benefits associated with the procedure. They exhibit realistic goals and have no acute psychological contraindications that would interfere with their ability to provide informed consent or adhere to post-operative recovery protocols.

At this time, [Patient Name] is psychologically cleared to proceed with the elective cosmetic surgery.

If you require any further information or wish to discuss this evaluation in more detail, please do not hesitate to contact my office.

Sincerely,

[Signature]
[Your Full Name, Credentials]
[License Number]
[Practice Name]
[Phone Number]
[Email Address]