[Date]

[Surgeon Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

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

Dear Dr. [Surgeon Last Name],

I am writing to provide the results of the psychological evaluation for [Patient Name], who is seeking [Type of Surgery, e.g., Gastric Bypass/Sleeve] surgery.

The evaluation was conducted on [Date] and included a clinical interview and a review of the patient's psychiatric history. The assessment focused on the patient's motivation for surgery, understanding of the required lifestyle changes, presence of active eating disorders, and stability of any underlying mental health conditions.

Evaluation Findings:

- **Psychiatric History:** [Briefly describe history or state "No significant history"].
- **Current Status:** The patient is currently [stable/well-managed] and demonstrates a clear understanding of the risks and benefits of the procedure.
- **Cognitive Readiness:** The patient shows adequate knowledge of the post-operative dietary requirements and the necessity of long-term follow-up care.
- **Social Support:** The patient has identified a support system to assist during the recovery period.

Recommendation:

Based on this evaluation, [Patient Name] is **cleared** from a psychiatric perspective to proceed with bariatric surgery. I have no psychological contraindications to the procedure at this time.

Recommendations for post-operative care include: [Optional: e.g., continued individual therapy, attendance of support groups].

If you require any further information, please feel free to contact my office.

Sincerely,

[Signature]
[Name of Evaluator, Degree]

[Title/License Number]
[Phone Number]