[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Surgeon Name]
[Surgical Practice Name]
[Address]

RE: Medical Clearance for Bariatric Surgery
Patient Name: [Patient Name]
Date of Birth: [DOB]
Insurance ID: [Insurance ID Number]

To Whom It May Concern,

I am writing to provide medical clearance for my patient, [Patient Name], to undergo [Type of Surgery, e.g., Gastric Sleeve/Gastric Bypass] surgery. I have been the primary care physician for this patient since [Year/Date].

Medical History:
The patient has a BMI of [BMI] and suffers from the following obesity-related comorbidities:
- [Comorbidity 1, e.g., Type 2 Diabetes]
- [Comorbidity 2, e.g., Hypertension]
- [Comorbidity 3, e.g., Obstructive Sleep Apnea]

Evaluation and Risk Assessment:
I have reviewed the patient's recent laboratory results, EKG, and physical examination. Based on my evaluation, the patient is medically stable and is a suitable candidate for general anesthesia and major abdominal surgery. The patient's chronic conditions are currently managed as follows: [Briefly mention management, e.g., stable on medication].

Weight Loss History:
The patient has made multiple unsuccessful attempts at supervised weight loss through diet and exercise. It is my clinical opinion that bariatric surgery is medically necessary to reduce the patient's risk of long-term morbidity and mortality.

Recommendation:
I provide full medical clearance for [Patient Name] to proceed with bariatric surgery. I will continue to follow the patient post-operatively to manage their primary care needs and adjust medications as weight loss occurs.

If you require further information, please contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]