[Date]

[Surgeon's Name]
[Surgeon's Practice Name]
[Address]
[City, State, Zip Code]

RE: Medical Clearance for Bariatric Surgery

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance ID: [ID Number]

Dear Dr. [Surgeon's Last Name],

I am writing to provide medical clearance for my patient, [Patient Name], who is seeking to undergo bariatric surgery. I have served as this patient's primary care physician for [Length of Time].

The patient has a current BMI of [BMI] and a weight of [Weight]. Their medical history includes the following obesity-related comorbidities:

- [Comorbidity 1, e.g., Type 2 Diabetes]
- [Comorbidity 2, e.g., Hypertension]
- [Comorbidity 3, e.g., Obstructive Sleep Apnea]

In my professional opinion, the patient is medically stable to undergo general anesthesia and the proposed surgical procedure. I believe the benefits of surgical weight loss intervention outweigh the risks, given their history of unsuccessful supervised weight loss attempts.

The patient is compliant with their current medication regimen and understands the necessary lifestyle and dietary changes required post-operatively. I am committed to collaborating with your team for their long-term follow-up care.

Please feel free to contact my office at [Phone Number] if you require further documentation or clinical records.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Practice Name]
[NPI Number]