[Date]

[Surgeon Name]
[Surgical Clinic 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 psychiatric evaluation results for [Patient Name], who is seeking clearance for [Type of Bariatric Procedure]. I conducted a formal clinical interview and psychological assessment on [Date of Evaluation].

The evaluation focused on the patient's psychiatric history, current mental status, understanding of the procedure, and their readiness for the significant lifestyle changes required post-surgery. My findings are as follows:

- **Psychiatric History:** The patient [has no history of / has a stable history of] psychiatric disorders. [If applicable, mention stability of current medications].
- **Cognitive Understanding:** The patient demonstrates a clear understanding of the risks, benefits, and necessary dietary restrictions associated with the surgery.
- **Motivation and Support:** The patient expresses realistic expectations for weight loss and has a demonstrated support system in place.
- **Substance Use:** There is no evidence of active substance abuse or untreated eating disorders that would contraindicate surgery at this time.

Based on this evaluation, it is my professional opinion that [Patient Name] is emotionally and psychologically cleared to proceed with bariatric surgery. I recommend continued follow-up with [Mental Health Provider/Support Group] during the postoperative period to ensure long-term success.

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

Sincerely,

[Signature]
[Printed Name, Credentials]
[License Number]
[Phone Number]
[Email Address]