Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Fax/Email: [Fax Number or Email Address]

RE: Medical Clearance for Bariatric Surgery

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Procedure: [Type of Bariatric Surgery]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for pulmonary clearance regarding the upcoming bariatric surgical procedure. My assessment included a review of the patient's medical history, physical examination, and the following diagnostic tests: [List tests, e.g., PFTs, Sleep Study, CXR].

Pulmonary Diagnosis:

- [Diagnosis 1, e.g., Obstructive Sleep Apnea]
- [Diagnosis 2, e.g., Asthma/COPD/Restrictive Lung Disease]

Clinical Findings:

[Insert brief summary of test results, e.g., PFTs show mild restriction; Sleep study confirms OSA with AHI of XX].

Recommendations and Optimization:

- The patient is compliant with CPAP/BiPAP therapy (Settings: [Insert Settings]).
- The patient should continue all respiratory medications until the day of surgery.
- Post-operative recommendations: [e.g., Early ambulation, use of CPAP in PACU, incentive spirometry].

Clearance Status:

From a pulmonary standpoint, the patient is: **CLEARED FOR SURGERY**

If you have any questions or require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]