Date: [Date]

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

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for sleep medicine clearance prior to their upcoming bariatric procedure. Below is the summary of the sleep medicine evaluation:

Diagnosis:
[ ] Obstructive Sleep Apnea (OSA) - Severity: [Mild / Moderate / Severe]
[ ] No evidence of Sleep Apnea based on [Date] sleep study
[ ] Other: [Specify]

Treatment and Compliance:
[ ] Patient is currently using PAP therapy (CPAP/BiPAP).
[ ] Compliance data has been reviewed; patient is compliant with usage >4 hours/night.
[ ] Current settings: [Pressure Settings].
[ ] Patient has been instructed to bring their PAP device to the hospital on the day of surgery.

Perioperative Recommendations:
1. Continuous PAP therapy should be utilized in the immediate postoperative period, including during recovery/PACU.
2. Minimize the use of sedative medications and opioids if possible to reduce the risk of respiratory depression.
3. Pulse oximetry monitoring is recommended postoperatively while the patient is using analgesics.

Clearance Status:
[ ] The patient is **CLEARED** from a Sleep Medicine standpoint for the requested procedure.
[ ] The patient is cleared pending the following: [Conditions].

If you have any questions regarding this evaluation, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Board Certification]

[Practice Name]
[Phone Number]