[Date]

To: [Surgeon Name]
[Surgical 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 Last Name],

I am writing to provide medical clearance for my patient, [Patient Name], to undergo bariatric surgery ([Type of Procedure, e.g., Gastric Bypass/Sleeve Gastrectomy]).

The patient has been under my care since [Year/Date] for the management of morbid obesity and its associated comorbidities, which include:

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

The patient has attempted several supervised weight loss programs including [List attempts, e.g., nutritional counseling, exercise programs, or medications] but has been unable to maintain significant long-term weight loss. We have discussed the risks and benefits of the surgical procedure, and the patient demonstrates a clear understanding of the necessary lifestyle changes required for post-operative success.

Based on my recent physical examination and review of the patient's medical history, [Patient Name] is medically stable and is a suitable candidate for anesthesia and the proposed surgical intervention. I recommend the following perioperative precautions: [List precautions or N/A].

If you require any further documentation or have questions regarding this patient's medical history, please contact my office at [Phone Number].

Sincerely,

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