[Physician Name, MD/DO]

[Practice Name]

[Address]

[City, State, Zip Code]

[Phone Number]

[Date]

To: [Surgeon Name/Bariatric Program Name]

Subject: Medical Clearance for Bariatric Surgery

Patient Name: [Patient Name]
Date of Birth: [DOB]
Patient BMI: [BMI]

To whom it may concern,

I am writing to provide medical clearance for my patient, [Patient Name], for bariatric surgery, specifically [Procedure Type, e.g., Gastric Sleeve/Bypass]. I have been the patient's primary care physician for [Length of Time].

Medical History:
The patient has a history of morbid obesity and the following comorbidities:
- [Comorbidity 1, e.g., Type 2 Diabetes]
- [Comorbidity 2, e.g., Hypertension]
- [Comorbidity 3, e.g., Obstructive Sleep Apnea]

Medical Stability:
The patient's chronic conditions are currently [Stable/Well-managed]. Recent laboratory results and physical examination indicate that the patient is a suitable candidate for general anesthesia and major abdominal surgery. I have reviewed the patient's current medications and have discussed the necessary perioperative adjustments.

Weight Loss Efforts:
The patient has attempted supervised weight loss through [Methods, e.g., diet, exercise, pharmacotherapy] for a period of [Number] months/years with insufficient long-term success. I believe that surgical intervention is medically necessary to mitigate the risks associated with their obesity.

Clearance Statement:
Based on my evaluation, I find no medical contraindications to proceeding with the bariatric procedure. From a primary care standpoint, the patient is medically cleared for surgery.

Please feel free to contact my office if you require further documentation or have additional questions.

Sincerely,

[Physician Signature]

[Physician Printed Name]