Medical Clearance Request for Bariatric Surgery

Date: [Insert Date]

To: [Surgeon's Name]

[Surgeon's Office/Facility Name]

[Office Address]

[City, State, ZIP Code]

Dear [Surgeon's Name],

I am writing to request medical clearance for my patient, [Patient's Full Name], who is seeking bariatric surgery. [Patient's Last Name] has been evaluated for this procedure and has met the necessary criteria.

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Medical Record Number: [Patient's MRN]
- Diagnosis: [Relevant Medical Conditions]

[Patient's Last Name] has undergone thorough assessments, including nutritional and psychological evaluations, and is committed to the post-operative lifestyle changes necessary for successful weight loss.

Please let us know if you require any additional information or documentation. We appreciate your assistance in providing the necessary medical clearance for this important procedure.

Thank you for your attention to this matter. We look forward to your prompt response.

Sincerely,

[Your Name]

[Your Title]

[Your Institution or Practice Name]

[Your Contact Information]