

# Referral for Gastric Bypass Procedure Evaluation

Date: [Insert Date]

To Whom It May Concern,

I am writing to refer my patient, [Patient's Name], who has been under my care since [Start Date of Care]. [Patient's Name] is a [Age] year-old [Gender] with a history of obesity and [any relevant medical conditions].

After thorough assessment and consideration, I believe [Patient's Name] is a suitable candidate for evaluation for gastric bypass surgery due to the following reasons:

- Current weight: [Current Weight] lbs
- Height: [Height] inches
- Body Mass Index (BMI): [BMI]
- Previous weight loss attempts: [Details of Attempts]
- Associated co-morbidities: [List of Co-morbidities]

Given [his/her] medical history and ongoing challenges with weight management, I believe a surgical approach may provide [Patient's Name] with a better quality of life. I kindly request a comprehensive evaluation for gastric bypass to determine [his/her] candidacy for this procedure.

Please feel free to contact me at [Your Phone Number] or [Your Email] should you require any additional information.

Thank you for your consideration.

Sincerely,

[Your Name], [Your Credentials]  
[Your Practice Name]  
[Your Address]  
[City, State, Zip Code]