

Primary Care Physician Letter of Medical Necessity

RE: _____
Patient's name _____ *DOB* _____

My patient has been under my care since _____. I am supportive of my patient having weight loss surgery and give consent specifically for:

- Gastric bypass Sleeve gastrectomy Adjustable gastric band

Despite numerous attempts, my patient has been unsuccessful long-term with all non-surgical weight loss. Surgical intervention is the remaining option. I have counseled the patient regarding weight loss and healthy lifestyles and *I believe my patient makes a good candidate for surgery.*

- I have included a copy of my office progress notes for the past six months.
 Patient hasn't smoked in the past 6 months.
 Patient hasn't been treated for nor has a history of substance abuse within the past year
 If female, counseled to not get pregnant for at least 18 months post-surgery

Yearly weights and BMI's for the past three years are:

Date/Year _____ Weight _____ BMI _____

Date/Year _____ Weight _____ BMI _____

Date/Year _____ Weight _____ BMI _____

My patient's medical diagnoses include:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depressions	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Pre-diabetes	<input type="checkbox"/> GERD	<input type="checkbox"/> Heart failure
<input type="checkbox"/> Hypertension	<input type="checkbox"/> PCOS	<input type="checkbox"/> Obesity
<input type="checkbox"/> Arthritis	<input type="checkbox"/> CAD	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> PVD	<input type="checkbox"/> Other

Medications include:

Primary Care Physician signature

Date

Address _____ *State* _____ *Zip Code* _____

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