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 five years are:

Date/Year_____ Weight_____ BMI_____

Date/Year_____ Weight_____ BMI_____

Date/Year_____ Weight_____ BMI_____

My patient's medical diagnoses include:

□ **Diabetes**	□ **Depressions**	□ **Renal disease**
□ **Pre-diabetes**	□ **GERD**	□ **Heart failure**
□ **Hypertension**	□ **PCOS**	□ **Obesity**
□ **Arthritis**	□ **CAD**	□ **Heart disease**
□ **Dyslipidemia**	□ **PVD**	□ **Other**

Medications include:

_____

_____

_____

_____
Primary Care Physician signature *Date*

*Address*_____*State*_____*Zip Code*_____

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