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## Cardiac Clearance for Bariatric Surgery

Date \_\_\_\_\_

I am writing to support the plan for my patient,

\_\_\_\_\_ ,  
to undergo Bariatric surgery.

Based on a pre-operative evaluation, which included if needed a full history, physical examination, review of systems, review of medications, 2D echocardiogram, stress test, and cardiac catheterization (attach copies as need be), this patient has no cardiac contraindications for the planned Bariatric surgery. This patient is cleared from my point of view, with the following restrictions, if any:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Fax number

PATIENT INITIAL EACH PAGE: \_\_\_\_\_ Date: \_\_\_\_\_