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Medical Clearance Form

(Completed by primary care or other physician directly related to patient care)

Patient Name: ___________________________
Date of Birth: ___________________________

Patients in the pre-operative process for Bariatric Surgery are required to obtain medical clearance from their primary care physician prior to scheduling surgery. Thank you for your assistance in preparing this patient for his/her upcoming bariatric surgery. Please complete this form and return to our office.

Physician *Printed* Name: ____ Phone: _________________________
Practice Address: ______________________________________ City/State: ____________________ Zip: ___________

Medical Examination:

Patients five (5) year weight history is as follows:
(1) YR:______ (2) YR:______ (3) YR: ______ (4) YR: ______ (5) YR: ______

The patient has been diagnosed with the following co-morbid conditions; associated with morbid obesity:
(please check all that apply)

- ☐ Type 2 diabetes – controlled by oral medications
- ☐ Type 2 diabetes – controlled by injectable meds
- ☐ Obstructive sleep apnea
- ☐ Coronary Artery disease
- ☐ Valvular Heart disease
- ☐ Dyslipidemia
- ☐ GERD
- ☐ Stress Incontinence
- ☐ Heart burn
- ☐ Hypertension
- ☐ Other conditions associated with morbid obesity: ____

Patient has attempted and been unsuccessful with the following weight loss programs:

- ☐ Physician directed diabetes – length ___________
- ☐ Weight Watchers – length __________
- ☐ dietician/nutrition directed – length ___________
- ☐ Physician directed low calorie – length ____________
- ☐ Jenny Craig – length _________
- ☐ Atkins/low carb – length _____________
- ☐ Other: __________________________- length __________

Wt: _____________ Ht: _____________ BP: _____________ P: _____________ R: ___________ Temp: ___________
Lungs: ____
Heart: ____
Additional comments: ____
____

This patient is cleared for bariatric surgery from a medical standpoint. YES NO

____ / / ___________
(Physician Signature) (Date)