

<Month/Date/Year>

<Surgeon Name>

Center for Obesity Surgery & Treatment
6400 Newberry Rd – Suite 106
Gainesville, FL 32605

Sample

RE: Pre-Surgical Assessment of _____

Dear Dr. _____:

Thank you for the referral of _____, a _____-year-old <race>, <marital status>, <gender> who presents today for evaluation of his/her psychological appropriateness for <specific surgical weight loss procedure>.

The patient was born in _____ and raised in _____. He/She currently lives in _____ and has been employed as a _____ for the past _____ years. Prior to this, he/she worked _____. He/She has _____ children.

At the present time his/her weight impacts her lack of relationships and poor family life. He/She is unable to do things for himself/herself and employs others to do simple household tasks for him/her. He/She is in relatively good health, complaining only of arthritis and pain in her back, legs, feet and ankles. He/She does find himself/herself exhausted upon exertion. He/She has had no problems with the law, no substance abuse issues, and has taken no psychotropic medications.

The patient has felt he/she has always been obese and has attended <List unsuccessful attemptst; such as, Nutri Systems and Weight Watchers, and has tried the Atkins Diet and over-the-counter medications>. He/She has not used any prescription medications following a consultation with her physician.

The MMPI-2 was administered and he/she was found to have a defensive test-taking attitude. However, he/she showed no significant pathology.

I recommend the patient would be a good candidate for <weight loss procedure>.

Yours truly,

<Licensed Psychologist>