

## SAMPLE LETTER FROM PRIMARY CARE PHYSICIAN

### ON PRIMARY MEDICAL DOCTOR'S PROFESSIONAL LETTERHEAD

(Date)

RE: (Patient's Name)

(Date of Birth)

Dear Dr. Buchin:

Mr./Mrs./Ms. (Name of Patient) has been a patient of mine for \_\_\_ years. The patient is (height) and weighs (weight in lbs.) with a BMI of \_\_\_\_\_. The patient has been excessively overweight for (period of time) and having attempted and been unsuccessful at many different methods of weight loss, would certainly benefit from Bariatric surgery.

In addition to morbid obesity, the patient is suffering from the following co-morbid conditions: (e.g. diabetes, hypertension, obstructive sleep apnea, hypercholesterolemia, hyperlipidemia, ASHD, exertional dyspnea, urinary incontinence, degenerative joint disease, osteoarthritis, PVD, shortness of breath, etc.)

**\*\*The patient has tried many methods of weight loss including diet pills (SPECIFIC DATES & LENGTH OF TIME) with (# of pounds lost and whether it was regained or not), Physician administered diets for (SPECIFIC DATES & LENGTH OF TIME) with (# of pounds lost and whether it was regained or not), etc. The patient is limited due to his/her co-morbidities in the ability to exercise but has tried (LIST ALL ATTEMPTS AND ANY SUCCESSES OR REGAINING OF WEIGHT). The patients weights have been (LIST ALL DATES AND WEIGHTS)**

Family medical history is positive for (e.g. Obesity, hypertension, diabetes, hypercholesterolemia, etc.)

I feel that my patient would benefit greatly from bariatric surgery as a tool to help lose the excess weight, lessen the co-morbidities and regain a more healthful life.

Sincerely,

PMD

#### **\*\*NOTE TO PCP**

**DUE TO INSURANCE CO. REQUIREMENTS, WE MUST HAVE WRITTEN DOCUMENTATION OF FAILED MEDICAL MANAGEMENT INCLUDING A STRUCTURED, PROFESSIONALLY OR PHYSICIAN-SUPERVISED WEIGHT LOSS PROGRAM FOR A MINIMUM OF 6 CONSECUTIVE MONTHS PRIOR TO THE RECOMMENDATION FOR BARIATRIC SURGERY. THIS SHOULD INCLUDE PERIODIC WEIGHTS, DIETARY THERAPY & PHYSICAL EXERCISE, AS WELL AS BEHAVIORAL THERAPY, COUNSELING AND PHARMACOTHERAPY AS INDICATED. A COPY OF YOUR MEDICAL CHART NOTES WOULD SERVE AS APPROPRIATE DOCUMENTATION IF YOU DO NOT WANT TO PUT THIS INFORMATION IN YOUR LETTER.**

**Please mail or fax the report to our office at: 516-233-3605**

**David Buchin, MD**

**1999 Marcus Ave.**

**Suite 106C**

**Lake Success, NY 11042**

PMD Letterhead

Date

Dr. David Buchin  
1999 Marcus Avenue  
Lake Success, NY 11042

RE: Pt Name    DOB

Dear Dr.Buchin,

Please be advised ..... was seen in this office in March of 2006. At that time the patient's weight was .... lbs at .....tall with a BMI of ..... She currently weighs ..... lbs.

..... has been working with me in relation to weight loss efforts and obesity related disorders. .... has tried various diet plans with little success. Very few pounds are lost and those few are quickly regained.

The patient suffers with .....ie .diabetes, hypertention, varicose veins.....and an esophageal hernia. She suffers from multiple symptoms of morbid obesity including fatigue and shortness of breath....joint pain

From .....Month.....year, through Month.....Year , ...pt. name..... has attempted a low calorie diet under my care. I have counseled her/her on a monthly basis regarding food choices and calorie intake, in conjunction with her related health problems. Increased physical activity has also been advised, but not achieved.

Her/his weights are as follows:

date.....weight  
date.....weight  
date.....weight  
date.....weight  
date .....weight  
date.....weight  
date.....weight

I believe that the patient has exhausted non-surgical weight loss therapies and should be considered for bariatricsurgery.

Sign

PMD