DATE:	
TO: **ATTN**:	**Fax**:
From: BODY BY BARIATRICS, LLC	
Pages (*including cover*): 2	
REQUEST: Pre-Operative Medical Clearance **Patient Name:** **DOB:**	

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BodyByBariatrics
3030 Harden Blvd., Bldg 1
Lakeland, FL 33803-7952
Office: 407-707-5018
Fax: 407-707-8658

Date:

Patient Name:
DOB:
Physician:
_____ Dr. Elizabeth Dovec, NPI 1962706606
_____ Dr. Diana Panciera Lane, NPI 1992233936

The following clinical information is being requested to obtain Pre-Operative Medical Clearance for the following planned procedure on ________________.

______ Laparoscopic Sleeve Gastrectomy
______ Laparoscopic Roux-en-Y Gastric Bypass
______ Laparoscopic Sleeve to Bypass Revision
______ Laparoscopic Band to Bypass Revision

- History & Physical
- EKG
- Labs
    - HbA1C
    - CMP
    - CBC with differential

Once a medical clearance has been made, please send all documentation and results by email (Support@BodyByBariatrics.com) or via fax (407-707-8658).

Should you have any questions or require additional clinical information, please contact me.

Sincerely,
BodyByBariatrics