BODY BY
BARIATRICS
SURGICAL WEIGHT LOSS

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
4901 Vineland Rd 150
Orlando, FL 32811
Office: 407-707-5018
Fax: 407-707-8658

BODY BY
BARIATRICS
SURGICAL WEIGHT LOSS

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

TO BE COMPLETED BY CLEARING PROVIDER:

Based on my review of the following documents, patient is medically cleared for the above surgery.

_____ History & Physical
_____ Labs (CMP, CBC, HbA1C)
_____ EKG image and interpretation
_____ Other: _____
***Please ensure all documents above are dated within 30 days of surgery!**

Clearing Provider's Name: _____

Signature: _____ Date: _____

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PLEASE FAX THIS BACK WITH THE CLINICAL ITEMS REQUESTED TO 407-707-8658!

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