New Life
Center For Bariatric Surgery

Dr. K. Robert Williams, MD, FACS, FASMBS

Request for Medical Clearance from Primary Care Physician

Patient's Name: _____

Patient's Date of Birth: _____

Dear Physician,

We are currently evaluating your patient for bariatric surgery. To facilitate obtaining approval from the patient's insurance, we need the following:

1. A letter stating that your patient is "recommended and cleared" (this exact verbiage is required by some insurances) to undergo bariatric surgery. Please acknowledge previous weight loss attempts and comorbid conditions.

2. Documentation that the patient's Flu and Pneumonia vaccinations are UTD according to current recommendations

3. Previous weight history for ☐ Not needed ☐ 1 year ☐ 2 years ☐ 3 years ☐ 5 years

4. Medically supervised diet visits, must be monthly, consecutive without missing a month.
Total visits required: ☐ Not needed ☐ 4 months ☐ 6 months ☐ 7 months

Please fax this requested information to 865-588-3742

Thank you for your assistance and please feel free to contact me if you have any questions.

Sincerely,

9330 Park West Blvd., Suite 508, Physicians Plaza, Knoxville, TN 37923

Phone 865-694-9676