Trinity Bariatric & Weight Loss Center
1500 Johns Road Suite 3
Augusta, Ga. 30904
Telephone: (706)-481-7298 Fax: (706)-481-7971

Medical Clearance and Post-Operative Care

Patient: ________________________________

Date of Birth:______________________________

I am aware that my patient named above is having weight loss surgery. I am aware they will need careful follow-up in the next several years. I agree to continue to follow this patient post-operatively and patient is considered a good or an acceptable candidate for bariatric surgery from a medical perspective.

Attending Physician name: ______________________________

Attending Physician signature: ___________________________

Date: ____