Date: [Date]

To: [Cardiologist Name]
Fax: [Cardiologist Fax Number]
Phone: [Cardiologist Phone Number]

RE: Cardiology Clearance for [Patient Name]
Date of Birth: [Patient DOB]

Dear Dr. [Cardiologist Last Name],

Your patient, [Patient Name], is scheduled for the following surgical procedure: [Name of Procedure] on [Date of Surgery].

The surgery will be performed at [Facility Name] by Dr. [Surgeon Name]. This procedure involves [General/Local/Mac] anesthesia.

To ensure the safety of the patient, we request a formal cardiac evaluation and clearance. Please provide the following information:

- Current cardiac diagnoses and clinical status.
- Assessment of perioperative cardiac risk.
- Recommendations regarding current cardiac medications (specifically anticoagulants or antiplatelets).
- Copies of recent EKG, Stress Test, or Echocardiogram results (if performed within the last 6-12 months).
- Specific instructions for intraoperative or postoperative management.

Please fax the clearance form and supporting documentation to our office at [Office Fax Number] or email it to [Email Address].

If you have any questions, please contact our office at [Office Phone Number].

Sincerely,

[Your Name/Surgeon Name]
[Practice Name]