Date: [Date]

To: [Surgeon Name]
Department: [Surgical Department/Clinic]
Fax/Email: [Recipient Contact Info]

RE: Preoperative Medical Clearance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Proposed Procedure: [Name of Surgery]
Surgery Date: [Date of Procedure]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for preoperative medical clearance regarding the aforementioned procedure. My assessment is as follows:

1. Medical History:
The patient has a history of [List chronic conditions, e.g., Hypertension, Type 2 Diabetes, Asthma].

2. Physical Examination:
Vitals: BP [00/00], HR [00], SpO2 [00%].
Cardiac: [e.g., Regular rhythm, no murmurs].
Respiratory: [e.g., Clear to auscultation].

3. Diagnostic Results:
[List relevant EKG, Lab work, or Imaging results].

4. Medications and Management:
- [Medication A]: [Continue/Hold] on the day of surgery.
- [Medication B]: [Instructions].

5. Assessment and Recommendations:
Based on my evaluation, the patient is at **[Low / Moderate / High]** risk for perioperative complications. From a medical standpoint, the patient is:

- [ ] Cleared for surgery without further intervention.
- [ ] Cleared for surgery pending [Specific Requirements].
- [ ] Not cleared at this time due to [Reason].

6. Functional Capacity:
The patient's functional capacity is estimated at [Number] METs.

Please contact my office at [Phone Number] if you have any questions or require further documentation.

Sincerely,

[Provider Signature]
[Provider Name, Credentials]
[Clinic/Practice Name]