Date: [Date]

To: [Surgeon Name]
Department: [Surgical Department]
Facility: [Facility Name]

RE: Preoperative Medical Clearance
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Proposed Procedure: [Procedure Name]
Surgery Date: [Date of Surgery]

Dear Dr. [Surgeon Last Name],

I have performed a preoperative medical evaluation on the above-named patient, who is considered **high-risk** due to the following comorbidities: [List conditions, e.g., CAD, COPD, Stage 3 CKD, Diabetes Mellitus].

Current Clinical Status:
The patient is currently [stable/compensated]. Recent diagnostic tests including [ECG/Stress Test/Labs/PFTs] performed on [Date] indicate [Brief summary of findings].

Risk Stratification:
According to [ASA Class/RCRI Index], the patient is categorized as [Insert Level] risk for major adverse cardiac or pulmonary events.

Perioperative Recommendations:

- **Medication Management:** [List medications to hold or continue, e.g., Hold ACE inhibitors 24 hours prior; continue Beta Blockers].
- **Anticoagulation:** [Instructions for bridging or stopping blood thinners].
- **Monitoring:** Recommend [e.g., invasive arterial monitoring, post-operative ICU bed, telemetry].
- **Glycemic Control:** [Specific instructions for diabetic management].

Clearance Statement:
The patient is medically cleared for the proposed procedure, provided the above recommendations and optimizations are implemented. The benefits of the surgery appear to outweigh the elevated perioperative risks discussed with the patient.

If you have any questions or require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Specialty/Internal Medicine]
[Contact Information]