Date: [Date]

To: [Surgeon Name]
Department: [Surgical Department]
Facility: [Hospital/Surgical Center Name]

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for medical clearance regarding the above-referenced procedure. Based on the patient's history, physical examination, and clinical status, they are considered a **low-risk candidate** for surgery and anesthesia.

Medical Summary:

- **Active Medical Conditions:** [List conditions or state "None"]
- **Medications:** [List current medications]
- **Allergies:** [List allergies]
- **Functional Capacity:** [e.g., Greater than 4 METs]

Preoperative Testing:
Recent laboratory results and/or EKG (if performed) were reviewed and are within acceptable limits for this procedure.

Recommendations:

- Continue all routine medications unless otherwise instructed by the surgical team.
- Patient is cleared for the scheduled procedure under [General/Local/MAC] anesthesia.
- No further cardiac or pulmonary workup is required at this time.

If you require any additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name/Clinic]