Date: [Date]

To: [Surgeon Name]
Department: Orthopedic Surgery
Facility: [Hospital/Clinic Name]

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] regarding their medical readiness for the upcoming orthopedic procedure. My assessment is based on a physical examination, review of medical history, and recent diagnostic testing.

Medical History & Chronic Conditions:
[List conditions, e.g., Hypertension, Diabetes, CAD, etc.]

Current Medications:
[List medications or attach list]

Recent Test Results:
- EKG: [Result/Date]
- Labs (CBC/BMP/PT/INR): [Results/Date]
- Other: [e.g., Chest X-ray, Stress Test]

Perioperative Recommendations:
- [e.g., Hold Aspirin 7 days prior]
- [e.g., Continue Beta Blockers on morning of surgery]
- [e.g., Insulin dosage adjustment]

Clearance Status:
[ ] The patient is cleared for surgery without restrictions.
[ ] The patient is cleared for surgery with the specific recommendations listed above.
[ ] The patient is NOT cleared for surgery at this time due to: [Reason].

Based on my clinical evaluation, the patient is at [Low / Moderate / High] risk for perioperative complications. From a medical standpoint, the patient is optimized for the proposed orthopedic intervention.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Phone Number]