Date: [Date]

To: [Surgeon Name]
[Ophthalmology Practice Name]
[Address]

RE: Medical Clearance for Cataract Surgery

Patient Name: [Patient Name]
Date of Birth: [DOB]
Scheduled Surgery Date: [Surgery Date]

Dear Dr. [Surgeon Last Name],

I am the primary care physician for [Patient Name]. I have reviewed the patient's medical history and performed a physical examination to evaluate their stability for cataract surgery under [Local Anesthesia / MAC / General Anesthesia].

Medical History:
[List chronic conditions, e.g., Hypertension, Diabetes, CAD]

Current Medications:
[List medications, specifically noting anticoagulants or antiplatelets]

Vitals:
BP: [BP Reading] | HR: [Heart Rate] | Temp: [Temp]

Recommendations:
[Select one: Continue / Hold] blood thinners [Number] days prior to surgery.
[Other specific instructions]

Clearance Status:
The patient is medically stable and cleared for the proposed procedure.

Sincerely,

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