**Date:** [Date]

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

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

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**Dear Dr. [Surgeon Last Name],**

I have performed a comprehensive geriatric preoperative evaluation on the above-named patient. My assessment and recommendations are as follows:

## 1. Medical Stability and Risk Stratification

**Current Medical Conditions:** [List conditions, e.g., Hypertension, AFib, Type 2 Diabetes]

**Cardiac Status:** [e.g., Stable, METS > 4, RCRI Score]
**Pulmonary Status:** [e.g., Clear lungs, OSA risk, Smoking status]

## 2. Geriatric-Specific Assessment

- **Cognitive Status:** [e.g., Intact / Known Dementia / Baseline Mini-Cog score]
- **Functional Status:** [e.g., Independent in ADLs / Requires assistance]
- **Frailty Scale:** [e.g., Clinical Frailty Scale score]
- **Delirium Risk:** [e.g., High / Moderate / Low]

## 3. Medication Management

**Medications to HOLD:** [e.g., ACE inhibitors, Anticoagulants, NSAIDs]
**Medications to CONTINUE:** [e.g., Beta-blockers, Statins]

## 4. Specific Recommendations

- **Fluid Management:** [Recommendations]
- **Pain Management:** [e.g., Avoid Meperidine/NSAIDs, suggest multimodal approach]
- **Post-operative Delirium Prevention:** [e.g., Frequent re-orientation, early mobilization, avoid benzodiazepines]
- **Post-operative Care:** [e.g., Physical therapy, Discharge to SNF vs Home]

## 5. Conclusion

The patient is **[Cleared / Cleared with High Risk / Not Cleared]** for the proposed procedure from a geriatric medical standpoint, provided the above recommendations are implemented.

Sincerely,

[Your Signature]
[Your Name, MD/DO]
[Department of Geriatrics/Internal Medicine]
[Contact Information]