Date: [Insert Date]

To: [Ophthalmologist Name]
Clinic Name: [Clinic Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Intravitreal Anti-VEGF Injection

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

Dear Dr. [Ophthalmologist Last Name],

I am writing regarding the medical clearance for the above-named patient to undergo intravitreal anti-VEGF injection(s) for the treatment of [Insert Condition, e.g., Wet AMD / Diabetic Retinopathy].

Medical History:
The patient is currently being managed for the following conditions: [List relevant conditions, e.g., Hypertension, Diabetes, Coronary Artery Disease].

Cardiovascular Status:
[ ] The patient has not had a myocardial infarction or stroke within the last 3-6 months.
[ ] The patient's blood pressure is currently stable and controlled.

Anticoagulation Status:
The patient is currently taking: [List medications, e.g., Aspirin, Warfarin, Clopidogrel, or "None"].
It is my recommendation that these medications [SHOULD / SHOULD NOT] be continued during the period of intravitreal injections.

Clearance Decision:
[ ] The patient is **CLEARED** for intravitreal anti-VEGF therapy from a systemic standpoint.
[ ] The patient is **NOT CLEARED** at this time due to: [Insert Reason].

Please feel free to contact my office if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Specialty, e.g., Primary Care/Cardiology]
[Phone Number]