[Doctor's Name/Letterhead]
[Clinic Address]
[Phone Number]
[Date]

RE: Pre-Operative Vein Mapping Clearance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Scheduled Procedure: [Type of Surgery, e.g., CABG/Arterial Bypass]

To [Surgeon's Name/Surgical Department],

This letter confirms that the above-named patient has undergone a pre-operative venous duplex ultrasound (vein mapping) on [Date of Exam] for the purpose of surgical planning.

Clinical Findings:
The bilateral upper/lower extremities were evaluated for conduit suitability. Findings include:
- Great Saphenous Vein (GSV) Patency: [Clear/Occluded]
- Small Saphenous Vein (SSV) Patency: [Clear/Occluded]
- Cephalic/Basilic Vein Patency: [Clear/Occluded]
- Minimum Diameter: [Measurement] mm
- Evidence of Deep Vein Thrombosis (DVT): [None/Specific Findings]

Clearance Status:
Based on the mapping results, the patient is cleared from a vascular standpoint for the planned procedure. The identified veins appear suitable for use as a surgical conduit. [Include any specific contraindications if found].

Please contact our office at [Phone Number] if you require the full ultrasound report or images.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Credentials]