

Date: [Insert Date]

To: [Primary Care Physician Name]

Fax/Email: [Physician Contact Information]

RE: Medical Clearance for Reconstructive Surgery

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Scheduled Surgery Date: [Surgery Date]

Dear Dr. [Physician Last Name],

Your patient, [Patient Name], is scheduled to undergo a reconstructive surgical procedure consisting of [Specific Name of Procedure] under [Type of Anesthesia, e.g., General Anesthesia] at our facility.

To ensure the safety of the patient, we request a formal medical clearance and a recent preoperative evaluation. Please provide the following information:

- A summary of the patient's current medical history and stable chronic conditions.
- A list of current medications and dosages.
- Recent physical examination findings.
- Specific clearance for the patient to undergo surgery and anesthesia.
- Any recommendations for perioperative management (e.g., cardiac precautions, medication adjustments).

Please include copies of any relevant diagnostic tests performed within the last [Number, e.g., 6] months, such as:

- Complete Blood Count (CBC) and Metabolic Panel (CMP)
- EKG/ECG (if applicable)
- [Additional Required Tests]

Please fax the completed clearance and supporting documents to our office at [Your Fax Number] or email them to [Your Email Address] by [Deadline Date].

If you have any questions or concerns regarding this surgical plan, please contact our office at [Your Phone Number].

Sincerely,

[Your Name/Surgeon Name]

[Practice/Facility Name]