

Date: [Date]

To: [Surgeon Name]

Facility: [Hospital/Surgical Center Name]

Fax/Email: [Contact Information]

RE: Medical Clearance for Surgery

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Proposed Procedure: [Name of Surgery]

Date of Surgery: [Surgery Date]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for preoperative medical clearance. Based on my physical examination, clinical history, and review of diagnostic tests, my assessment is as follows:

Medical History & Clinical Findings:

- Active Medical Conditions: [List conditions, e.g., Hypertension, Diabetes]
- Current Medications: [List medications or attach list]
- Allergies: [List allergies]
- Vital Signs: BP: [Reading], HR: [Reading], O2 Sat: [%]

Review of Systems / Cardiac Risk:

[Insert brief summary, e.g., Patient denies chest pain or shortness of breath. Exercise tolerance is adequate.]

Diagnostic Test Results:

- EKG: [Normal/Abnormal - Date]
- Laboratory Work: [Within normal limits / Significant findings]
- Other (CXR/Stress Test): [If applicable]

Pre-Operative Recommendations:

- Medication Management: [e.g., Hold anticoagulants 5 days prior; take BP meds morning of surgery]
- Diabetes Management: [e.g., Hold oral hypoglycemics morning of surgery]

Clearance Status:

The patient is **MEDICALLY CLEARED** for the proposed procedure under [General/Local/MAC] anesthesia.

If you have any questions or require further information, please contact my office at [Phone Number].

Sincerely,

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