[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Surgeon Name]
Re: Pre-Operative Medical Clearance for Diabetes Management

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Scheduled Procedure: [Name of Surgery]
Date of Surgery: [Surgery Date]

To whom it may concern,

I am the primary care physician/endocrinologist for [Patient Name]. I have evaluated the patient's diabetic status for the upcoming surgical procedure. The following information summarizes their current health status and perioperative recommendations:

Clinical Status:
- Diagnosis: [Type 1 / Type 2 Diabetes]
- Most recent HbA1c: [Value]% (Date: [Date])
- Current Fasting Glucose Range: [Range] mg/dL

Current Medications:
- Oral Medications: [List medications and dosages]
- Insulin Regimen: [List insulin types and dosages]

Perioperative Management Plan:
- Day Before Surgery: [Instructions regarding medication adjustments]
- Day of Surgery (NPO): [Instructions for holding or adjusting insulin/medications]
- Target Blood Glucose Range during surgery: [Range] mg/dL

Clearance Status:
[ ] The patient is medically cleared for the scheduled procedure from a diabetic standpoint.
[ ] The patient is cleared with the following specific precautions: [List precautions]

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]