

**Date:** [Date]

**To:** [Requesting Surgeon's Name]

**Department:** [Surgical Department]

**Facility:** [Facility Name]

**RE: Neurological Pre-Operative Clearance**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Proposed Procedure:** [Procedure Name]

**Surgery Date:** [Date of Surgery]

To Whom It May Concern,

I have evaluated [Patient Name] for neurological clearance prior to the above-referenced surgical procedure. My assessment is based on a clinical examination, review of medical history, and [List any specific tests: e.g., MRI, EEG, EMG].

**Neurological Diagnosis:**

[List primary neurological conditions, e.g., Epilepsy, Parkinson's Disease, Multiple Sclerosis, History of Stroke]

**Current Neurological Status:**

The patient's condition is currently [Stable/Optimized/Controlled]. [Add brief note on current symptoms or deficits].

**Recommendations for Perioperative Management:**

- **Medications:** [Instructions on whether to continue or hold neuro-specific medications, e.g., anti-epileptics or anti-platelets].
- **Seizure/Stroke Risk:** [Specific precautions if applicable].
- **Anesthesia Considerations:** [Specific neurological concerns for anesthesia].
- **Post-Operative Care:** [Instructions for monitoring mental status or neurological deficits].

**Clearance Status:**

The patient is [**Cleared / Cleared with the above recommendations**] from a neurological standpoint to proceed with the planned surgery under [General/Regional/Local] anesthesia.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Board Certification/Neurology Specialty]

[Practice Name/Contact Information]