Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Fax: [Fax Number]

RE: Medical Clearance for Surgery

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Proposed Procedure: [Type of Orthopedic Surgery]
Surgery Date: [Date of Surgery]

To whom it may concern,

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance regarding the aforementioned orthopedic procedure. Based on my physical examination, clinical history, and review of diagnostic tests, my findings are as follows:

Medical History & Clinical Findings:

- **Vital Signs:** [BP, Pulse, Temp]
- **Known Conditions:** [List chronic conditions, e.g., Hypertension, Diabetes]
- **Medications:** [List current medications]
- **Allergies:** [List allergies]

Testing Results:

- **EKG:** [Normal/Abnormal - provide details]
- **Lab Work:** [Significant findings or 'Within normal limits']
- **CXR (if applicable):** [Results]

Medication Instructions:

[Instructions regarding anticoagulants, aspirin, or diabetic medications prior to surgery]

Clearance Status:

The patient is **medically cleared** for the proposed surgery under [General/Local/Spinal] anesthesia. [Optional: Risk status, e.g., "The patient is considered a low/moderate surgical risk."]

Recommendations:

[Additional notes or post-operative care recommendations]

Sincerely,

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