Date: [Date]

To: [Surgeon Name]
Facility: [Hospital/Surgical Center Name]
Fax/Email: [Contact Information]

RE: Pre-Operative Medical 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] regarding their medical readiness for the above-referenced procedure. My assessment included a physical examination, review of systems, and a review of recent diagnostic testing.

Current Medical Conditions:

- [Condition 1, e.g., Hypertension]
- [Condition 2, e.g., Type 2 Diabetes]
- [Condition 3, e.g., Atrial Fibrillation]

Geriatric Assessment & Functional Status:

- **Cognitive Status:** [Normal / Mild Cognitive Impairment / Dementia]
- **Functional Status:** [Independent / Requires Assistance with ADLs]
- **Frailty Scale:** [Score/Category]
- **Fall Risk:** [Low / Moderate / High]

Cardiac and Pulmonary Status:

- **Metabolic Equivalents (METs):** [e.g., > 4 METs]
- **EKG Findings:** [Result/Date]
- **Lung Sounds:** [Clear / Significant Findings]

Perioperative Recommendations:

- **Medication Management:** [List medications to hold or continue, e.g., Hold blood thinners X days prior]
- **Diabetes Management:** [Instructions for insulin/oral meds on morning of surgery]
- **Post-Op Delirium Precautions:** [Recommendations for monitoring or avoiding certain medications]

Medical Impression:

The patient is **cleared for surgery** from a medical standpoint, provided that the above recommendations are followed. The patient is at [Low / Moderate / High] risk for perioperative complications due to [Reason].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Practice Name]