

**Date:** [Date]

**To:** [Surgeon Name/Surgical Facility Name]

**Fax:** [Fax Number]

**RE: Pediatric Pre-Operative Medical Clearance**

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

**Date of Birth:** [Patient DOB]

**Proposed Procedure:** [Procedure Name]

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

To Whom It May Concern,

I have performed a pre-operative history and physical examination on the above-named patient on [Date of Exam]. Based on my evaluation, the patient is medically cleared for the scheduled procedure under [General/MAC/Local] anesthesia.

**Clinical Findings:**

- **Vital Signs:** Temp: [ ] HR: [ ] RR: [ ] BP: [ ] O2 Sat: [ ]
- **Height/Weight:** [ ] / [ ]
- **Heart:** [Normal/Abnormal Findings]
- **Lungs:** [Normal/Abnormal Findings]
- **Airway:** [Normal/Mallampati Score]

**Medical History:**

- **Allergies:** [List or NKDA]
- **Current Medications:** [List Medications and Dosages]
- **Past Medical History:** [List chronic conditions, e.g., Asthma, CHD]
- **Previous Anesthesia Issues:** [None or specify]

**Recommendations:**

[Insert specific instructions, e.g., "Continue asthma inhalers until morning of surgery" or "Patient requires SBE prophylaxis"]

**Clearance Status:**

The patient is cleared for surgery without further testing or restrictions at this time.

Sincerely,

[Physician Signature]

[Physician Printed Name], MD/DO

[Practice Name]  
[Phone Number]