

**Date:** [Date]

**To:** [Surgeon Name]

**Facility:** [Hospital/Surgical Center Name]

**RE: Medical Clearance for Surgery**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Proposed Procedure:** [Procedure Name]

**Surgery Date:** [Surgery Date]

To Whom It May Concern,

I have evaluated [Patient Name] for preoperative medical clearance regarding the aforementioned procedure. Based on the patient's history, physical examination, and current clinical status, they are considered **low-risk** for perioperative cardiovascular and systemic complications.

**Clinical Findings:**

- **Vital Signs:** BP: [BP], HR: [HR], Temp: [Temp], SpO2: [SpO2]%
- **Medical History:** [Briefly list relevant history or "None"]
- **Medications:** [List medications or "None"]
- **Allergies:** [List allergies]

**Recommendations:**

- The patient is cleared for the planned procedure under [General/Local/MAC] anesthesia.
- Continue all routine medications unless otherwise directed by the surgical team.
- No further preoperative diagnostic testing is indicated at this time.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[License Number]