Date: [Date]

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

RE: Medical Clearance for Surgery

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

To Whom It May Concern,

I am the primary care provider for [Patient Name]. I have performed a physical examination and reviewed the patient's medical history, current medications, and laboratory results in preparation for the above-mentioned elective cosmetic procedure.

Medical History & Findings:

- **Current Medications:** [List medications or "None"]
- **Allergies:** [List allergies or "NKDA"]
- **Chronic Conditions:** [List conditions or "None"]
- **Recent Vitals:** BP: [BP], Pulse: [Pulse], Temp: [Temp]

Laboratory/Diagnostic Results:

[Insert summary of CBC, BMP, EKG, or other relevant tests here]

Assessment:

Based on my evaluation, the patient is currently in stable health. From a medical standpoint, the patient is cleared for the proposed surgery under [General/Local] anesthesia.

Recommendations:

[List any specific instructions, such as: "Hold aspirin 7 days prior" or "Continue blood pressure medication on morning of surgery"]

If you require any further information or have questions regarding this clearance, please contact my office at [Phone Number].

Sincerely,

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