

Date: [Date]

To: [Surgeon Name]

Clinic/Facility: [Clinic Name]

Fax/Email: [Contact Information]

RE: Pre-Operative Cardiac Clearance

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Proposed Procedure: [Name of Cosmetic Surgery]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] on [Date of Evaluation] for cardiac risk stratification prior to their scheduled cosmetic surgery. My assessment included a physical examination, review of medical history, and the following diagnostic tests:

- EKG (Dated: [Date]): [Normal / Specific Findings]
- [Additional Test, e.g., Stress Test/ECHO]: [Results]

Cardiac History: [Brief summary of cardiac conditions or "None"]

Current Medications: [List cardiac medications or "None"]

Clinical Assessment:

Based on the revised cardiac risk index and the patient's functional capacity (>4 METS), the patient is currently in stable cardiovascular condition. From a cardiac standpoint, the patient is:

Cleared for surgery without restrictions.

Cleared for surgery with the following recommendations: [List recommendations, e.g., continue specific medications, beta-blocker protocol, etc.]

The patient has been advised to [resume/hold] anticoagulation therapy as follows: [Specific Instructions].

Please feel free to contact my office if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Cardiology Practice Name]

[Phone Number]