

**Date:** [Date]

**To:** [Surgeon Name]  
[Surgical Practice Name]  
[Address]

**RE: Medical Clearance for Breast Augmentation Surgery**

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

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

Dear Dr. [Surgeon Last Name],

I am writing to provide medical clearance for [Patient Name] regarding their upcoming elective breast augmentation surgery scheduled for [Surgery Date].

The patient has been under my care for [Duration of Time]. Based on a recent physical examination and a review of their medical history, I find the patient to be in good general health and medically stable to undergo general anesthesia and the proposed surgical procedure.

**Clinical Findings:**

- **Current Medications:** [List medications or "None"]
- **Known Allergies:** [List allergies or "NKDA"]
- **Relevant Labs/Tests:** [Include results for CBC, EKG, or Mammogram if applicable]
- **Chronic Conditions:** [List conditions or "None"]

**Recommendations:**

- [Instruction 1, e.g., Continue current medications as prescribed]
- [Instruction 2, e.g., Discontinue NSAIDs 7 days prior to surgery]

In my professional opinion, there are no contraindications to proceeding with the surgery at this time. Should you have any questions or require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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