

[Physician's Office Letterhead]

**Date:** [Date]

**To:** [Surgeon's Name/Surgical Center Name]

**Address:** [Surgeon's Address]

**RE: Pre-Surgical Clearance for Liposuction**

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

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

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance prior to undergoing elective liposuction surgery under [Local/General] anesthesia.

**Medical History & Physical Examination:**

The patient's medical history was reviewed, and a physical examination was performed. The patient has a history of [List relevant conditions or "no significant medical history"]. Current medications include [List medications or "None"].

**Diagnostic Results:**

The following tests were reviewed and found to be within normal limits for this procedure:

- CBC (Complete Blood Count): [Results/Date]
- BMP (Basic Metabolic Panel): [Results/Date]
- Coagulation Studies (PT/PTT/INR): [Results/Date]
- EKG: [Results/Date]
- Pregnancy Test (if applicable): [Results/Date]

**Assessment:**

Based on the clinical findings and test results, the patient is currently in stable condition. From a [Internal Medicine/Primary Care] standpoint, the patient is medically cleared for the proposed surgical procedure.

**Recommendations:**

[List any specific instructions, e.g., "Continue all medications" or "Hold aspirin 7 days prior"]

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]  
[License Number]  
[Contact Information]