

[PCP Name]
[PCP Practice Name]
[PCP Address]
[PCP Phone Number]
[Date]

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

RE: Medical Clearance for [Patient Full Name] (DOB: [Patient Date of Birth])

Dear [Surgeon Name],

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance regarding the following planned cosmetic procedure: [Name of Procedure].

Medical History and Physical Exam:

The patient's current medical history includes: [List conditions or state "None"].
Current medications: [List medications or state "None"].
Known allergies: [List allergies or state "NKDA"].
Vital Signs: BP [00/00], HR [00], BMI [00].

Review of Systems:

Cardiovascular: [Normal/Abnormal]
Respiratory: [Normal/Abnormal]
Other relevant findings: [Optional]

Diagnostic Results (if applicable):

Lab Work (CBC/BMP): [Normal/Abnormal]
EKG Results: [Normal/Abnormal/Not Required]

Physician Statement:

Based on my clinical evaluation and the patient's stable medical status, [Patient Name] is medically cleared for the proposed surgery and general anesthesia. I recommend the following precautions: [List precautions or state "None"].

Please contact my office at [PCP Phone Number] if you have any questions.

Sincerely,

[Signature]
[PCP Printed Name]
[License Number/NPI]