Date: [Date]

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

RE: Medical Clearance for Anesthesia and Surgery

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

To Whom It May Concern,

I have evaluated the above-named patient regarding their medical fitness for the upcoming procedure under anesthesia. Based on my clinical examination and review of their medical history, my findings are as follows:

Medical Diagnoses:

- [Diagnosis 1]
- [Diagnosis 2]
- [Diagnosis 3]

Current Medications:

- [Medication Name and Dosage]
- [Medication Name and Dosage]

Assessment:

The patient's chronic conditions are currently [stable/optimized/well-controlled]. From a [Cardiac/Pulmonary/Internal Medicine] standpoint, the patient is considered:

[ ] **Cleared** for the procedure with routine monitoring.
[ ] **Cleared** for the procedure with the following recommendations: [Specific instructions regarding medications or monitoring].

Recommendations for Perioperative Management:

[e.g., Hold Aspirin 7 days prior, continue Beta Blockers on morning of surgery, etc.]

If you require any further documentation or have questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Title/Specialty]
[Medical License Number]