**Date:** [Date]

**To:** [Surgeon Name]
**Facility:** [Surgical Center Name]
**Fax/Email:** [Contact Information]

**RE: Medical Clearance for Outpatient Cosmetic Surgery**

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

To Whom It May Concern,

I am the primary care provider for [Patient Name]. I have performed a physical examination and reviewed the patient's medical history in preparation for their upcoming outpatient cosmetic surgery scheduled for [Surgery Date].

**Medical History & Findings:**

- **Current Diagnoses:** [List conditions or state "None"]
- **Medications:** [List current medications]
- **Allergies:** [List allergies]
- **Vital Signs:** BP: [Blood Pressure], HR: [Heart Rate]
- **Lab Results:** [Note if attached or if results are within normal limits]

**Physician Statement:**

Based on my clinical evaluation, the patient is currently stable. From a medical standpoint, the patient is cleared to undergo the planned outpatient procedure under [Local/General/IV Sedation] anesthesia.

**Recommendations:**
[Specific instructions regarding medication adjustments or post-operative care, or state "None"]

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic Name]
[License Number]