Date: [Date]

To: [Dentist/Oral Surgeon Name]
Facility: [Dental Clinic Name]
Fax/Phone: [Clinic Contact Information]

RE: Medical Clearance for Dental Procedure
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

Dear Dr. [Dentist Last Name],

The patient named above is currently under my care for the management of the following pulmonary conditions:
[List conditions, e.g., COPD, Asthma, Obstructive Sleep Apnea, etc.]

Current Pulmonary Status:
[Stable / Guarded / Optimized]

Latest Pulmonary Function Test (PFT) Results (if applicable):
Date: [Date]
FEV1: [Value] FVC: [Value] FEV1/FVC: [Value]

Sedation/Anesthesia Recommendation:
I have reviewed the proposed dental procedure involving [Local Anesthesia / IV Sedation / General Anesthesia]. From a pulmonary standpoint, the patient is:
[ ] Cleared for the procedure without restrictions.
[ ] Cleared for the procedure with the following precautions.

Specific Precautions/Comments:
[e.g., Maintain oxygen saturation above 92%, use bronchodilator pre-procedure, avoid specific medications, etc.]

Current Respiratory Medications:
[List medications]

Please feel free to contact my office at [Phone Number] if you require further information regarding this patient's respiratory health.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Pulmonology Practice Name]
[Phone Number]