Date: [Date]

To: [Surgeon Name]
Department: [Surgical Department/Hospital Name]
Fax/Contact: [Fax Number or Email]

RE: Medical Clearance for Cardiac Surgery

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for preoperative medical clearance regarding the aforementioned cardiac procedure. Based on my clinical examination, review of medical history, and recent diagnostic tests, my assessment is as follows:

1. Cardiovascular Status:
[Stable/Optimized/High Risk]. Recent findings: [List EKG, Echo, or Stress Test results].

2. Chronic Medical Conditions:
[List conditions such as Hypertension, Diabetes, COPD, etc., and their current management status].

3. Medications and Anticoagulation Plan:
Current Medications: [List].
Preoperative Instructions: [Specify when to stop aspirin, clopidogrel, anticoagulants, or diabetic medications].

4. Recommendations:
[e.g., Continue beta-blockers, monitor potassium levels, specific pulmonary instructions].

5. Clearance Determination:
[ ] The patient is medically cleared for the proposed surgery.
[ ] The patient is cleared with the following specific precautions: [List precautions].
[ ] The patient is not cleared at this time due to: [Reason].

If you require further documentation or wish to discuss this patient's status, please contact my office at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name, MD/DO]

[Specialty/Clinic Name]
[Phone Number]