

Date: [Date]

To: [Surgeon Name]

Department: [Surgical Department/Hospital Name]

Re: Cardiac Clearance for [Patient Full Name]

Date of Birth: [Patient DOB]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for preoperative cardiac risk assessment prior to the scheduled [Name of Procedure].

Medical History:

The patient is a [Age]-year-old with a history of [List conditions, e.g., Coronary Artery Disease, Hypertension, Atrial Fibrillation]. Current functional capacity is estimated at [Number] METs.

Clinical Findings:

- Recent EKG (Date: [Date]): [Results]
- Recent Stress Test/Echo (Date: [Date]): [Results]
- Vital Signs: BP [BP], HR [HR]

Medication Management:

- Antiplatelets/Anticoagulants: [Instructions to stop/continue, e.g., Hold Aspirin 5 days prior]
- Beta Blockers/Statins: [Instructions to continue]
- Other: [Additional instructions]

Geriatric Considerations:

Due to the patient's age, care should be taken regarding [mention frailty, cognitive status, or renal dosing]. We have discussed the risks of postoperative delirium and specialized geriatric nursing care is recommended.

Impression:

The patient is [**Cleared / Cleared with High Risk / Not Cleared**] for the proposed surgery from a cardiovascular standpoint, provided the above recommendations are followed.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Cardiology/Internal Medicine]

[Phone Number]