

Date: [Date]

To: [Surgeon Name/Surgical Department]

Facility: [Hospital Name]

Fax/Email: [Contact Information]

RE: Medical Clearance for Heart Valve Replacement Surgery

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Proposed Procedure: [Type of Valve Replacement, e.g., Aortic/Mitral]

To Whom It May Concern,

I am the primary care physician/specialist for [Patient Name]. I have evaluated the patient for the purpose of medical clearance regarding the scheduled heart valve replacement surgery.

Current Medical Status:

The patient's medical history includes [List relevant conditions]. Their current medications are [List medications].

Examination and Testing:

The following assessments have been reviewed:

- Physical Examination: [Stable/Unstable]
- Laboratory Results (CBC, Chem7, Coagulation): [Normal/Abnormal]
- Electrocardiogram (EKG): [Results]
- Recent Imaging (Chest X-Ray/Echo): [Results]

Recommendations:

[Instructions regarding anticoagulants, e.g., Aspirin/Warfarin hold dates].

[Instructions regarding other chronic medications].

Clearance Status:

Based on my evaluation, the patient is **medically cleared** for the proposed surgery with [low/moderate] risk. No further preoperative testing is required at this time.

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

Sincerely,

Signature: _____

[Physician Name, MD/DO]
[Practice Name]
[License Number]