Date: [Date]

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

RE: Medical Clearance for Rotator Cuff Repair

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Surgery: [Surgery Date]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for preoperative medical clearance regarding the scheduled rotator cuff repair. Based on my clinical examination and review of the patient's medical history, I provide the following assessment:

Medical History & Diagnosis:
[List relevant conditions, e.g., Hypertension, Diabetes, etc.]

Medication Instructions:
[List medications to continue or hold, specifically blood thinners or NSAIDs]

Test Results:
[Include relevant results: EKG, Blood Work, or Chest X-ray if applicable]

Clearance Status:
The patient is **medically cleared** for the procedure under [General/Local] anesthesia. [Optional: Recommendations for intraoperative or postoperative care]

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]