Date: [Insert Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Fax: [Insert Fax Number]

RE: Medical Clearance for Total Hip Replacement

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Surgery Date: [Insert Surgery Date]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for preoperative medical clearance regarding a planned Total Hip Replacement. Based on my clinical examination and a review of the patient's medical history, I provide the following assessment:

Medical History & Chronic Conditions:
[List relevant conditions, e.g., Hypertension, Diabetes, COPD]

Recent Diagnostic Results:
EKG: [Normal/Abnormal - Date]
Labs: [CBC, BMP, PT/INR results within normal limits or specified]
CXR: [If applicable]

Medication Management:
[List instructions for stopping anticoagulants, NSAIDs, or diabetic medications]

Clearance Status:
The patient is **medically cleared** for the planned procedure under [General/Spinal] anesthesia. The patient is considered [Low/Moderate] risk for perioperative cardiac or pulmonary complications.

Recommendations:
[Insert specific instructions, e.g., "Continue Beta-Blocker on morning of surgery"]

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]