[Physician Name, MD/DO]
[Practice/Facility Name]
[Address Line 1]
[Address Line 2]
[Phone Number]
[Email]

Date: [Date]

To: [Surgeon Name]
[Surgical Practice Name]

RE: Medical Clearance for Anterior Cruciate Ligament (ACL) Reconstruction

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

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for preoperative medical clearance regarding their upcoming ACL reconstruction surgery scheduled for [Surgery Date].

Based on my physical examination, medical history, and review of recent laboratory results/diagnostic tests, I find the patient to be in stable health. From a [Internal Medicine/Cardiology/Primary Care] standpoint, the patient is cleared for the procedure under [General/Regional] anesthesia.

Medical History Summary:
[List relevant conditions or "None"]

Current Medications:
[List medications or "See attached list"]

Preoperative Instructions:
[e.g., Hold anticoagulants 5 days prior; Continue Beta-blockers morning of surgery]

If you have any questions or require further information regarding this patient's medical status, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]