Date: [Date]

To: [Surgeon Name]
[Surgical Practice Name]
[Address]

RE: Medical Clearance for Carpal Tunnel Release
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Proposed Surgery Date: [Surgery Date]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for medical clearance regarding the scheduled carpal tunnel release surgery. Based on my physical examination and review of the patient's medical history, I provide the following assessment:

Medical Diagnoses:
[List relevant conditions, e.g., Hypertension, Diabetes]

Current Medications:
[List medications or attach list]

Cardiac/Pulmonary Status:
[Note if stable or any specific concerns]

Pre-operative Instructions:
[Note if specific medications like blood thinners should be held and for how long]

Clearance Status:
The patient is **medically cleared** for the procedure under [Local/MAC/General] anesthesia. 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,

[Physician Signature]
[Physician Printed Name]
[Clinic/Practice Name]