Date: [Date]

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

RE: Medical Clearance for Arthroscopic Meniscus Repair

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

To Whom It May Concern,

I have evaluated [Patient Name] regarding their medical readiness for the scheduled arthroscopic meniscus repair under [General/Spinal/Local] anesthesia.

Medical History & Physical Findings:
The patient has a history of [List relevant conditions, e.g., Hypertension, Diabetes] which is currently [stable/well-controlled]. Vital signs and physical examination are within normal limits for surgical intervention.

Pre-operative Testing:
The following tests were reviewed:

- EKG: [Normal/Abnormal Findings]
- Labs (CBC/BMP/PT/INR): [Within Normal Limits/Specific Results]
- CXR (if applicable): [Results]

Medication Instructions:
[Instructions regarding blood thinners, NSAIDs, or diabetic medications, e.g., Hold Aspirin 7 days prior].

Clearance Status:
The patient is **medically cleared** for the proposed procedure from a primary care/cardiac standpoint. No further testing is required at this time.

Should you have any questions, please contact my office at [Phone Number].

Sincerely,

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