Date: [Date]

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

RE: Medical Clearance for Open Reduction Internal Fixation (ORIF) of Ankle Fracture

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

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance regarding the surgical repair of an ankle fracture. After a review of the patient's medical history, current medications, and physical examination, I provide the following assessment:

Medical History: [List chronic conditions or "None"]
Current Medications: [List medications or "None"]
Allergies: [List allergies]

Clinical Findings:
Blood Pressure: [Insert BP]
Heart Rate: [Insert HR]
Laboratory Results: [Summary of relevant labs, e.g., CBC, BMP, PT/INR]
EKG Results: [Summary of EKG if performed]

Clearance Status:
[ ] The patient is cleared for surgery without restrictions.
[ ] The patient is cleared for surgery with the following recommendations: [List recommendations, e.g., hold anticoagulants, adjust insulin].

In my clinical opinion, the patient is medically stable to undergo Open Reduction Internal Fixation (ORIF) under [General/Regional] anesthesia. The benefits of surgical stabilization outweigh the surgical risks from a medical standpoint.

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

Sincerely,

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