Date: [Date]

To: [Surgeon's Name]
[Surgical Facility/Clinic Name]
[Address]

RE: Medical Clearance for Shoulder Arthroplasty

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Proposed Surgery: [Total Shoulder Arthroplasty / Reverse Shoulder Arthroplasty]
Scheduled Date: [Surgery Date]

Dear Dr. [Surgeon's Last Name],

I have evaluated [Patient Name] for medical clearance regarding the above-referenced procedure. My evaluation included a physical examination, review of medical history, and relevant diagnostic tests.

Medical History:
The patient has a history of: [List chronic conditions such as Hypertension, Diabetes, etc.]. These conditions are currently [stable / well-controlled / optimized].

Current Medications:
[List medications or attach list]

Cardiac/Pulmonary Status:
[Describe status, e.g., Patient is asymptomatic from a cardiac standpoint with good exercise tolerance.]

Perioperative Recommendations:
1. [e.g., Hold blood thinners 5 days prior]
2. [e.g., Continue Beta Blockers on morning of surgery]
3. [e.g., Monitor glucose levels closely]

Clearance Status:
Based on my evaluation, the patient is **medically cleared** for shoulder arthroplasty under [General/Regional] anesthesia. The patient is at [Low/Intermediate] risk for perioperative complications.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Practice Name]
[Contact Information]