Date: [Date]

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

RE: Medical Clearance for High-Risk Cataract Surgery

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

Dear Dr. [Ophthalmologist Last Name],

I have evaluated [Patient Name] regarding their medical readiness for cataract surgery. I understand this case is classified as high-risk due to the following comorbidities: [List conditions, e.g., Uncontrolled Hypertension, Severe COPD, Anticoagulation Therapy, Cardiac Stents].

Medical Status Summary:

- **Cardiovascular:** [Status/Stability]
- **Respiratory:** [Status/Stability]
- **Metabolic:** [Status/HbA1c levels]
- **Medications:** [Note any blood thinners or alpha-blockers]

Perioperative Recommendations:

- **Anticoagulation:** [Continue / Hold / Bridge]
- **Anesthesia:** [Local / IV Sedation / General Anesthesia Recommended]
- **Monitoring:** [Special monitoring requirements during procedure]

Clearance Status:

The patient is **MEDICALLY CLEARED** for the procedure, provided the above recommendations are followed. The benefits of improved vision outweigh the surgical risks identified.

Sincerely,

[Physician Signature]
[Physician Name and Title]
[Practice Name]
[Phone Number]