Date: [Date]

To: [Ophthalmologist Name/Surgical Center Name]
Fax: [Fax Number]

RE: Medical Clearance for Cataract Surgery

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

Dear Dr. [Ophthalmologist Last Name],

The above-named patient is under my care for their general medical needs. I have evaluated the patient on [Date of Evaluation] to determine their fitness for elective cataract surgery under [Local/Monitored] anesthesia.

Medical History:
The patient has the following stable medical conditions:
[List conditions, e.g., Hypertension, Diabetes, CAD]

Medications:
[List current medications or attach list]

Anticoagulation:
The patient [is / is not] currently on anticoagulation or antiplatelet therapy. Recommendation for surgery: [Continue medication / Hold for X days].

Vital Signs:
BP: [BP] | HR: [HR] | SpO2: [SpO2]%

Assessment:
Based on my evaluation, the patient is medically stable and is at low risk for cardiovascular or respiratory complications during the proposed procedure.

Clearance Status:
[ ] Cleared for surgery without restrictions.
[ ] Cleared for surgery with the following recommendations: [Recommendations]

Please contact my office at [Phone Number] if you require further information.

Sincerely,

_____
[Physician Signature]

[Physician Name, MD/DO]
[Clinic Name]
[Contact Information]