Date: [Date]

To: [Ophthalmologist/Surgeon Name]
Facility Name: [Clinic/Hospital Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Cataract Surgery
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

Dear Dr. [Surgeon Last Name],

Mr./Ms. [Patient Last Name] is under my care for the management of chronic hypertension. I am providing medical clearance for the patient to undergo elective cataract surgery under local/topical anesthesia.

Cardiovascular Status:
The patient's blood pressure is currently [Stable/Optimized].
Recent Blood Pressure Reading: [BP Reading] mmHg taken on [Date].
Hypertension Classification: [Stage or Controlled status].

Current Medications:
[List antihypertensive medications and dosages]

Recommendations:
1. The patient should take all regular antihypertensive medications on the morning of the procedure with a small sip of water.
2. [Add instructions regarding anticoagulants/antiplatelets if applicable].
3. No specific cardiovascular contraindications to the procedure are noted at this time.

The patient is cleared for surgery from a primary care/cardiology standpoint, provided that blood pressure remains within acceptable limits on the day of the procedure.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Contact Information]