Date: [Insert Date]

To: [Surgeon Name/Ophthalmology Clinic Name]
Fax/Email: [Recipient Contact Information]

RE: Medical Clearance for Cataract Surgery

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] regarding their medical suitability for elective cataract surgery under [Local Anesthesia / Sedation].

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

Medications:
Current medications include:
[List medications or attach list]

Anticoagulation Status:
The patient [is / is not] on anticoagulation/antiplatelet therapy.
Recommendation: [Continue as normal / Hold for X days prior to surgery].

Physical Examination & Vitals:
BP: [Insert BP]
Heart Rate: [Insert HR]
Respiratory Status: [e.g., Lungs clear / Stable]
Cardiac Status: [e.g., No murmurs / Regular rhythm]

Clinical Impression:
[Patient Name] is currently medically stable. From a primary care perspective, the patient is cleared for the procedure as planned.

Special Precautions:
[List any specific concerns, e.g., patient cannot lie flat for long, requires oxygen, etc.]

Sincerely,

[Physician Signature]
[Physician Printed Name]

[Clinic Name]
[Phone Number]