Date: [Date]

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

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

Dear Dr. [Surgeon Last Name],

This letter is regarding the preoperative evaluation of the above-named patient for cataract surgery. The patient is currently under my care for [Indication for Anticoagulation, e.g., Atrial Fibrillation, Mechanical Valve, DVT].

Current Anticoagulant/Antiplatelet Medication: [Drug Name and Dosage]

Perioperative Management Plan:

- [ ] **Continue Medication:** The patient may remain on their current dose of [Medication Name] throughout the perioperative period, as the risk of thromboembolism outweighs the risk of surgical bleeding.
- [ ] **Hold Medication:** Please hold [Medication Name] for [Number] days prior to surgery. Resume medication [Number] days post-operatively.
- [ ] **Bridge Therapy:** Discontinue [Medication Name] [Number] days prior to surgery and initiate bridge therapy with [Low Molecular Weight Heparin Name/Dose].

Medical Clearance:
From a cardiovascular/hematological standpoint, the patient is:
[ ] Cleared for surgery.
[ ] Cleared for surgery with the following precautions: [List Precautions]

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Specialty]
[Clinic/Hospital Name]