URGENT MEDICAL CLEARANCE FOR SURGERY

Date: [Insert Date]

To: [Ophthalmologist/Surgeon Name]
Facility: [Facility Name]
Fax/Email: [Contact Info]

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

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] regarding their medical readiness for undergoing cataract surgery under [Local/MAC/General] anesthesia.

Medical History:
The patient has a history of: [List major conditions, e.g., Hypertension, Diabetes, CAD].

Current Medications:
[List medications or attach list]

Anticoagulation Status:
[ ] Patient is not on anticoagulants/antiplatelets.
[ ] Patient is on [Drug Name]. Instructions: [Continue / Hold X days prior].

Recent Vital Signs:
BP: [Insert BP] | HR: [Insert HR] | Glucose (if diabetic): [Insert Level]

Clearance Status:
[ ] The patient is **MEDICALLY CLEARED** for the scheduled procedure.
[ ] The patient is cleared with the following **RECOMMENDATIONS**: [Insert notes]

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Practice Name]
[Phone Number]