

Date: [Date]

To: [Specialist Name]
[Specialist Department/Clinic Name]
[Address]

RE: Medical Clearance for Mission Trip

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

Dear Dr. [Specialist Last Name],

The above-named patient is planning to participate in a short-term mission trip to [Destination Country] from [Start Date] to [End Date]. This trip will involve [Briefly describe physical demands, e.g., high heat, heavy lifting, remote location, limited access to advanced medical care].

As the patient's primary healthcare provider, I am requesting your specialist evaluation and clearance regarding their [Specific Medical Condition, e.g., Cardiac History, Type 1 Diabetes].

Please evaluate the patient and provide your recommendation on the following:

- The patient's current clinical stability regarding their specific condition.
- Their ability to tolerate the physical and environmental rigors of the trip.
- Any necessary adjustments to their medication or treatment plan during travel.
- Specific emergency protocols the patient should follow while abroad.

Please indicate below if the patient is medically cleared for this travel:

Cleared for travel without restrictions.

Cleared for travel with the following restrictions: [List restrictions]

Not cleared for travel at this time.

Specialist Signature: _____ Date: _____

Please return a copy of this assessment to my office via fax at [Fax Number] or email at [Email Address]. Thank you for your assistance in ensuring this patient's safety.

Sincerely,

[Your Name/Signature]
[Your Title]
[Clinic Name]
[Phone Number]