Date: [Date]

To: [Name of Psychiatrist/ECT Department]
Facility: [Facility Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Electroconvulsive Therapy (ECT)
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance to undergo Electroconvulsive Therapy (ECT). Based on my physical examination, medical history, and review of systems, I provide the following assessment:

1. Medical History and Diagnoses:
[List chronic conditions, e.g., Hypertension, Diabetes, CAD, etc.]

2. Current Medications:
[List all current medications and dosages]

3. Physical Examination Findings:
Vitals: [BP, HR, RR, Temp, SpO2]
Cardiovascular: [Findings]
Pulmonary: [Findings]
Neurological: [Findings]

4. Laboratory and Diagnostic Results:
CBC: [Results/Date]
BMP/CMP: [Results/Date]
EKG: [Results/Interpretation/Date]
[Other relevant tests, e.g., Chest X-ray, UA]

5. Assessment of Risk:
The patient is currently medically stable. From a primary care perspective, there are no absolute contraindications to the patient receiving general anesthesia and ECT at this time.

6. Recommendations:
[e.g., Hold specific medications on morning of procedure, continue beta-blockers, etc.]

Medical Clearance Status:
[ ] Cleared for ECT without restrictions.
[ ] Cleared for ECT with the following optimizations: [List requirements].
[ ] Not cleared at this time due to: [List reasons].

Sincerely,

[Provider Signature]
[Provider Name, Credentials]
[Clinic/Organization Name]
[Phone Number]