**Date:** [Date]

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

To the Referring Physician/Department of Psychiatry:

I have evaluated the above-named patient to assess their cardiovascular risk regarding the administration of Electroconvulsive Therapy (ECT). My evaluation included a review of their medical history, physical examination, and the following diagnostic tests: [List tests, e.g., EKG, Stress Test, Echocardiogram].

**Cardiovascular Diagnoses:**

- [Diagnosis 1]
- [Diagnosis 2]

**Clinical Findings & Stability:**
The patient is currently [stable/compensated] from a cardiovascular standpoint. Current medications include: [List relevant cardiac medications].

**Recommendations and Clearance:**

[ ] The patient is cleared for ECT without specific cardiovascular restrictions.
[ ] The patient is cleared for ECT provided the following precautions are taken:

- [e.g., Aggressive blood pressure control during procedure]
- [e.g., Pre-procedure beta-blocker administration]
- [e.g., Continuous EKG monitoring]

**Risk Stratification:**
Based on the patient's history of [Condition], there is a [low/moderate/high] risk of transient hypertension, tachycardia, or arrhythmia during the seizure and post-ictal phase. However, the benefits of ECT appear to outweigh the cardiac risks at this time.

Please contact my office at [Phone Number] if you have any questions or require further clarification.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Department of Cardiology]
[Facility Name]