[Neurologist Name/Clinic Name]
[Address]
[Phone Number]
[Date]

To: [Requesting Psychiatrist/Department Name]
Re: Neurology Clearance for Electroconvulsive Therapy (ECT)

Patient Information:

- Patient Name: [Patient Full Name]
- Date of Birth: [DOB]
- Medical Record Number: [MRN]

To whom it may concern,

I have evaluated the above-named patient regarding their neurological stability for Electroconvulsive Therapy (ECT). My assessment is based on [mention evaluation type: e.g., clinical examination, recent MRI/CT, or EEG].

Neurological History:
The patient has a history of [mention conditions: e.g., Epilepsy, Stroke, Intracranial Mass, or "No significant neurological history"].

Current Findings:
[Insert brief summary of current neurological status and stability of any existing conditions].

Recommendations and Precautions:

- The patient is currently taking the following anticonvulsants/neurological medications: [List medications or "None"].
- Specific risks identified: [e.g., Potential for prolonged seizure, increased intracranial pressure risks, or "None"].
- Management suggestions: [e.g., Adjust medication timing, monitor for post-ictal confusion, or "Proceed with standard protocol"].

Clearance Statement:
From a neurological standpoint, I find the patient to be [Cleared / Cleared with precautions / Not cleared] to undergo Electroconvulsive Therapy.

If you require further information, please contact my office.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Board Certification/Title]