Date: [Date]

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

To the Department of Psychiatry/ECT Service,

I have evaluated [Patient Name] for medical clearance prior to undergoing Electroconvulsive Therapy (ECT). My evaluation included a focused physical examination, review of systems, and the following diagnostic tests: [List tests, e.g., EKG, CBC, CMP].

Medical History:
[List relevant diagnoses, e.g., Hypertension, GERD, Diabetes]

Current Medications:
[List all current medications and dosages]

Cardiovascular/Respiratory Status:
[Note EKG findings and exercise tolerance or respiratory stability]

Recommendations:
[e.g., Continue antihypertensives on morning of procedure with a sip of water; Adjust insulin dose; No specific contraindications noted]

Clearance Status:
Based on my evaluation, the patient is **medically cleared** for ECT and the associated general anesthesia. There are no absolute medical contraindications to the procedure at this time. The patient is optimized for the planned treatment.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Department of Internal Medicine]
[Facility/Clinic Name]