Date: [Date]

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

To the ECT Program Director/Attending Psychiatrist,

I have evaluated the above-named patient to determine their medical stability for Electroconvulsive Therapy (ECT). Based on my physical examination and review of the diagnostic tests, my findings are as follows:

Medical History & Physical Exam:
[Brief summary of relevant medical conditions, e.g., stable hypertension, no recent cardiac events]

Review of Diagnostics:
- **ECG:** [Results/Date]
- **Laboratory Results (CBC, BMP, etc.):** [Results/Date]
- **Imaging (if applicable):** [Results/Date]

Current Medications:
[List relevant medications]

Recommendations for Anesthesia/Procedure:
[e.g., Hold specific medications on morning of treatment, continue beta-blockers, etc.]

Clearance Status:
[ ] The patient is medically cleared for ECT without specific restrictions.
[ ] The patient is medically cleared for ECT with the following precautions: [List precautions].
[ ] The patient is NOT cleared at this time due to: [List reasons].

Please feel free to contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[Clinic/Hospital Name]