Date: [Date]

To: [Psychiatrist Name/ECT Department]
From: [Physician Name/Primary Care Provider]
Facility: [Facility Name]
Re: Medical Clearance for Electroconvulsive Therapy (ECT)

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

Dear Dr. [Psychiatrist Last Name],

I have evaluated [Patient Name] for medical clearance prior to undergoing Electroconvulsive Therapy (ECT). Based on my physical examination, review of systems, and diagnostic tests, my findings are as follows:

Medical History:
[List relevant geriatric conditions such as Hypertension, Diabetes, CAD, Parkinson's, etc.]

Current Medications:
[List all medications and dosages]

Cardiac Status:
EKG Date: [Date] Results: [Findings]
[Note any history of MI, arrhythmias, or presence of a pacemaker/ICD]

Neurological Status:
[Note baseline cognitive status, history of stroke, or intracranial pressure concerns]

Laboratory Results:
CBC: [Results]
BMP/Electrolytes: [Results]
[Other relevant labs]

Clinical Impression:
The patient is medically stable to undergo ECT under general anesthesia. I recommend the following precautions:

- [e.g., Hold specific medications morning of procedure]
- [e.g., Monitor blood pressure closely post-treatment]
- [e.g., Adjustment of diabetic medications]

Clearance Status:
[ ] Cleared for ECT
[ ] Cleared for ECT with the recommendations listed above

Sincerely,

[Signature]
[Physician Name, Title]
[Contact Information]