Date: [Date]

To: [ECT Coordinator/Department Name]
Facility: [Hospital/Clinic Name]
Address: [Facility Address]

RE: Medical Clearance for Outpatient Electroconvulsive Therapy (ECT)

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To whom it may concern,

I am writing to provide medical clearance for the above-named patient to undergo outpatient Electroconvulsive Therapy (ECT). I have evaluated the patient and reviewed their recent medical history, physical examination, and diagnostic tests.

Medical Evaluation Summary:

- **Physical Exam:** [Stable/Normal/Comments]
- **Cardiac Status:** [e.g., EKG results, history of heart disease]
- **Respiratory Status:** [e.g., Asthma/COPD status]
- **Neurological Status:** [e.g., History of seizures or intracranial pressure]
- **Current Medications:** [List relevant medications]
- **Allergies:** [List allergies]

Laboratory and Diagnostic Results:

- CBC: [Results/Date]
- BMP/CMP: [Results/Date]
- EKG: [Results/Date]
- Other: [List additional tests if applicable]

Assessment:
Based on my evaluation, the patient is medically stable and is considered a [Low/Moderate] risk candidate for general anesthesia and the ECT procedure. There are no absolute medical contraindications to treatment at this time.

Specific Recommendations/Precautions:
[Note any specific instructions, such as medication adjustments on the morning of treatment or required monitoring].

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[License Number]
[Practice Name/Address]