Date: [Date]

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

RE: Medical Clearance for Electroconvulsive Therapy (ECT)

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

To Whom It May Concern,

I have performed a preoperative medical evaluation on the above-named patient to determine their suitability for inpatient Electroconvulsive Therapy (ECT) and associated general anesthesia.

Clinical Summary:
The patient is currently admitted for [Diagnosis/Indication]. Their medical history is significant for [List Major Comorbidities, e.g., Hypertension, GERD, Diabetes].

Evaluation Findings:

- **Physical Exam:** [Stable/Normal/Findings]
- **Vitals:** BP: [Result], HR: [Result], SpO2: [Result]
- **EKG Results:** [Date: Result/Normal/Stable]
- **Laboratory Results:** CBC, BMP, and [Other tests] are within acceptable limits for anesthesia.
- **Current Medications:** [List relevant medications or state "See attached list"]

Assessment and Recommendations:
From a medical standpoint, the patient is **CLEARED** for Electroconvulsive Therapy. [Insert specific precautions, e.g., "Continue beta-blockers on morning of procedure" or "Monitor glucose levels post-procedure"].

The patient is categorized as ASA Physical Status Class: [I/II/III/IV].

If you have any questions regarding this evaluation, please contact me at [Phone Number].

Sincerely,

[Signature]
[Printed Name, Degree]
[Title/Department]
[Hospital Name]