Date: [Date]

To: [Psychiatrist Name/ECT Department]
Facility: [Facility Name]
Fax: [Fax Number]

RE: Endocrinology Medical Clearance for Electroconvulsive Therapy (ECT)

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

Dear Dr. [Psychiatrist Last Name],

I have evaluated [Patient Name] regarding their endocrine status prior to undergoing Electroconvulsive Therapy (ECT). The patient is currently being managed for the following conditions:

- [Condition 1, e.g., Type 2 Diabetes]
- [Condition 2, e.g., Hypothyroidism]

Clinical Findings:
Current Medications: [List doses and frequency]
Recent Lab Results: [Insert A1c, TSH, or relevant electrolytes]
Vital Signs: [Blood Pressure/Heart Rate]

Management Recommendations for Procedure Days:

- **Diabetes Management:** [Instructions regarding NPO status, e.g., Hold morning insulin/oral meds, monitor fingerstick BG pre-procedure].
- **Thyroid/Steroid Management:** [Instructions regarding replacement doses].
- **Glucose Target:** Maintain blood glucose between [Range] mg/dL.

Clearance Status:
Based on the patient's current endocrine stability, [Patient Name] is medically cleared to proceed with ECT from an endocrinology standpoint, provided the above recommendations are followed.

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

Sincerely,

[Doctor Signature]
[Doctor Name, MD/DO]
[Department of Endocrinology]
[License Number]