Date: [Date]

To: [Name of Treating Psychiatrist/ECT Department]
Facility Name: [Hospital/Clinic Name]
Address: [Facility Address]

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

Dear Dr. [Psychiatrist Last Name],

I have evaluated [Patient Name] on [Date of Evaluation] for medical clearance to undergo Electroconvulsive Therapy (ECT). My assessment included a review of the patient's medical history, current medications, and a physical examination.

Medical History & Findings:
[Insert brief summary of relevant medical conditions, e.g., cardiovascular, respiratory, or neurological status]

Diagnostic Results:
The following tests were reviewed (as applicable):

- EKG: [Results/Date]
- Laboratory Work (CBC, BMP): [Results/Date]
- Other (CXR, Imaging): [Results/Date]

Medication Management:
[Instructions regarding holding or continuing specific medications on the morning of the procedure, e.g., antihypertensives or anticoagulants]

Clearance Status:
Based on my evaluation, the patient is medically:
[ ] **Cleared** for ECT and general anesthesia.
[ ] **Cleared with the following optimizations/precautions:** [List details]
[ ] **Not cleared** at this time due to: [List reasons]

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

Sincerely,

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