

**Date:** [Date]

**To:** [Fertility Specialist Name/Clinic Name]

**From:** [MFM Specialist Name/Practice Name]

**Subject:** Maternal-Fetal Medicine Clearance for IVF

**Patient Name:** [Patient Full Name]

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

Dear Dr. [Fertility Specialist Last Name],

I have evaluated [Patient Name] on [Date of Consultation] to assess her candidacy for In Vitro Fertilization (IVF) and subsequent pregnancy from a Maternal-Fetal Medicine perspective. My evaluation included a review of her medical history, current health status, and the following specific conditions: [List conditions, e.g., chronic hypertension, diabetes, prior pregnancy complications].

**Clinical Assessment:**

[Insert brief summary of clinical findings and stability of existing conditions].

**Recommendations:**

- [Recommendation 1: e.g., Optimization of specific medications]
- [Recommendation 2: e.g., Recommended embryo transfer limit (SET)]
- [Recommendation 3: e.g., Required monitoring during pregnancy]

**Clearance Status:**

Based on the current evaluation, [Patient Name] is medically cleared to proceed with IVF treatment. From a high-risk obstetric standpoint, she is deemed a suitable candidate for pregnancy, provided the aforementioned recommendations are followed and she remains under co-management with MFM once conception is achieved.

Should you have any questions regarding this clearance or require further documentation, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Name, MD/DO]

Maternal-Fetal Medicine Specialist

[Board Certifications]