

[Oncologist Name, MD/DO]  
[Department of Oncology]  
[Institution/Clinic Name]  
[Address]  
[Phone Number]

Date: [Date]

To: [Fertility Specialist Name]  
[Fertility Clinic Name]  
[Address]

**RE: Medical Clearance for In Vitro Fertilization (IVF) / Fertility Preservation**

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

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

**Diagnosis:** [Cancer Type and Stage]

Dear [Fertility Specialist Name],

I am the treating oncologist for [Patient Name]. This letter serves to provide medical clearance for the patient to undergo fertility preservation/In Vitro Fertilization (IVF) prior to commencing oncology treatment.

**Clinical Summary:**

The patient was diagnosed with [Diagnosis] on [Date]. The proposed oncology treatment plan includes [Chemotherapy/Radiation/Surgery], which is scheduled to begin on or around [Date].

**Clearance and Recommendations:**

- The patient is currently medically stable to undergo ovarian stimulation and oocyte/embryo retrieval.
- [Required for Hormone-Sensitive Cancers]: I recommend the use of letrozole or other aromatase inhibitors during stimulation to maintain low serum estradiol levels.
- The patient's current laboratory results (CBC, Coagulation Profile) are within acceptable limits for a minor surgical procedure.
- There are no contraindications to the use of anesthesia for the retrieval process.

**Time Sensitivity:**

Due to the nature of the malignancy, it is requested that the stimulation cycle be completed by [Deadline Date] to avoid significant delays in cancer therapy.

Please contact my office at [Phone Number] if you have any questions or require further clinical documentation.

Sincerely,

[Oncologist Signature]

[Oncologist Printed Name]

[Board Certification/Title]