**Date:** [Date]

**To:** [Primary Care Physician/Pediatrician Name]
**Facility:** [Clinic/Hospital Name]
**Fax/Email:** [Contact Information]

**RE: Post-Surgical Discharge Clearance**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [DOB]
**Date of Procedure:** [Date]
**Procedure Performed:** [Name of Surgery]

Dear Dr. [Physician Last Name],

This letter is to inform you that [Patient Name] has successfully completed their post-operative recovery phase following the procedure mentioned above. The patient was evaluated on [Follow-up Date] and has met all clinical criteria for discharge from surgical specialty care.

**Clinical Summary:**

- **Incision Site:** [e.g., Well-healed, no signs of infection]
- **Pain Management:** [e.g., Controlled with over-the-counter medication / discontinued]
- **Physical Activity:** [e.g., May return to full activities/sports without restrictions]
- **Vitals:** Stable and within normal limits for age.

**Follow-up Instructions:**

[Insert specific instructions regarding long-term monitoring or medication changes, if applicable].

The patient is now cleared to resume routine pediatric care under your supervision. We have advised the family to contact your office for regular check-ups or if any non-surgical concerns arise.

Thank you for your collaboration in this patient's care. Please contact our office at [Phone Number] if you require further documentation or have additional questions.

Sincerely,

[Surgeon Signature]
[Surgeon Name, Title]
[Department/Hospital Name]