Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Sleeve Gastrectomy

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Proposed Surgery Date: [Date]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for medical clearance regarding the proposed Laparoscopic Sleeve Gastrectomy. Based on my clinical examination, review of medical history, and recent diagnostic tests, I provide the following assessment:

Medical History & Diagnoses:
[List relevant conditions, e.g., Obesity, Type 2 Diabetes, Hypertension, OSA]

Clinical Findings:
The patient is currently stable. Recent lab work including CBC, CMP, and EKG have been reviewed and are [within normal limits / attached]. Blood pressure and glycemic levels are currently optimized for surgery.

Medication Management:
[Instructions for holding medications, e.g., hold blood thinners or NSAIDs 7 days prior to surgery].

Clearance Status:
The patient is **medically cleared** for the scheduled procedure from a [Primary Care / Cardiology / Pulmonology] standpoint. The patient is categorized as ASA Class [Number].

Recommendations:
[Insert specific perioperative instructions or "None"].

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Phone Number]