Date: [Date]

To: [Requesting Surgeon's Name]
Department: [Surgical Department]
Facility: [Hospital/Clinic Name]

RE: Pre-Operative Cardiac Clearance
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Scheduled Procedure: [Name of Surgery]
Surgery Date: [Date of Surgery]

Dear Dr. [Surgeon Last Name],

At your request, a transthoracic echocardiogram was performed on [Date of Test] to evaluate [Patient Name]'s cardiac function prior to their upcoming procedure.

Echocardiogram Results:

- **Left Ventricular Ejection Fraction (LVEF):** [Percentage]%
- **Wall Motion:** [Normal / Description of Abnormalities]
- **Valvular Function:** [Normal / Description of Stenosis or Regurgitation]
- **Right Ventricle/Atria:** [Normal / Description of Dilation or Pressure]

Clinical Assessment:
Based on the echocardiographic findings and the patient's current clinical status, the patient is considered [Low / Moderate / High] risk from a cardiovascular standpoint. There are no contraindications to proceeding with the planned surgery under [General / Monitored] anesthesia.

Recommendations:

- [Continue/Hold] cardiac medications as per standard pre-op protocol.
- [Instruction regarding beta-blockers or antiplatelets].
- [Post-operative monitoring requirements].

The patient is **CLEARED** for the scheduled procedure.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
Cardiology Department
[Contact Phone Number]