Date: [Insert Date]

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

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

To Whom It May Concern,

I have reviewed the pre-operative Liver Function Test (LFT) results for the above-named patient, performed on [Insert Date of Blood Work].

The results are as follows:

- ALT: [Value] U/L
- AST: [Value] U/L
- ALP: [Value] U/L
- Total Bilirubin: [Value] mg/dL
- Albumin: [Value] g/dL
- INR/PT (if applicable): [Value]

Medical Assessment:

Based on these results and the patient's clinical history, the patient is:
[ ] Medically cleared for the scheduled procedure from a hepatic standpoint.
[ ] Cleared with the following recommendations/precautions: [Insert Notes]

The patient has been advised to continue/hold the following medications: [Insert Medication Instructions].

If you require any further information or have questions regarding these results, please contact my office at [Insert Phone Number].

Sincerely,

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