[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Patient Name]
Address: [Patient Address]

Subject: URGENT REMINDER: Pre-Operative Medical Clearance Required

Dear [Patient Name],

This is a reminder regarding your upcoming surgical procedure scheduled for **[Date of Surgery]** with **[Surgeon Name]**.

Our records indicate that we have not yet received your required medical clearance. To ensure your safety and to avoid the cancellation or rescheduling of your surgery, we must receive the following documentation no later than **[Deadline Date]**:

- Physical examination report from your Primary Care Physician
- Blood work / Lab results
- EKG / Cardiac clearance (if applicable)
- [Additional Required Test]

Please contact your primary care doctor immediately to ensure these documents are faxed to our office at **[Fax Number]**. If you have already completed these tests, please call us to verify that we have received the results.

Failure to provide these documents by the deadline may result in your surgery being postponed.

If you have any questions, please contact our surgical coordinator at [Phone Number].

Sincerely,

[Sender Name/Office Manager]
[Clinic Name]