[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: IMPORTANT: Required Pre-Operative Clearance Appointment

Dear [Patient Name],

This is a reminder regarding your upcoming surgical procedure scheduled for **[Surgery Date]**. To ensure your safety and to proceed with the surgery, you are required to attend a pre-operative clearance appointment.

Your appointment is scheduled for:

- **Date:** [Appointment Date]
- **Time:** [Appointment Time]
- **Location:** [Facility Name/Department], [Room/Suite Number]
- **Provider:** [Doctor Name]

Required Preparation:

- Please bring a current list of all medications and supplements you are taking.
- Bring any recent lab results or cardiac reports from outside facilities.
- [Insert specific fasting instructions if applicable, e.g., Do not eat or drink 8 hours prior].

Failure to complete this clearance by **[Deadline Date]** may result in the postponement or cancellation of your surgery.

If you need to reschedule this appointment or have questions regarding your instructions, please call our office immediately at [Phone Number].

Thank you for your cooperation.

Sincerely,

[Sender Name/Department]
[Medical Facility Name]