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

RE: Post-Surgical Consultation Treatment Plan

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Consultation: [Consultation Date]

Dear [Patient Name or Referring Physician],

Following the specialist surgical consultation regarding [Condition/Diagnosis], the following treatment plan has been established:

1. Recommended Procedure
The recommended surgical intervention is [Name of Procedure]. The goal of this surgery is to [Purpose of Surgery, e.g., repair, remove, or alleviate symptoms].

2. Pre-Operative Requirements
Before proceeding with the surgery, the patient must complete the following:
- [Requirement 1, e.g., Blood tests]
- [Requirement 2, e.g., Cardiac clearance]
- [Requirement 3, e.g., Imaging studies]

3. Medication Management
- **Stop taking:** [List of medications to pause, e.g., blood thinners] by [Date].
- **Continue taking:** [List of medications to continue].
- **New prescriptions:** [List of pre-op or post-op medications].

4. Surgical Schedule
- **Proposed Date:** [Date]
- **Facility:** [Hospital or Surgery Center Name]
- **Arrival Time:** [Time]

5. Recovery and Post-Operative Care
- **Estimated Hospital Stay:** [Number of days or Outpatient]
- **Physical Restrictions:** [Details on lifting, driving, or work]
- **Follow-up Appointment:** [Date and Time]

6. Risks and Benefits
The benefits of the procedure include [Benefit]. Potential risks discussed include [Risk 1], [Risk 2], and [Risk 3].

Please contact our office at [Phone Number] if you have any questions or wish to proceed with scheduling.

Sincerely,

[Surgeon Name]
[Title/Specialty]
[Medical License Number]