[Doctor's Office Letterhead/Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Gastroenterologist Name or Facility Name]
Fax: [Fax Number]

RE: Medical Clearance for Colonoscopy

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Scheduled Procedure Date: [Date]

To Whom It May Concern,

I have evaluated the above-named patient regarding their fitness for a colonoscopy under [Sedation/General Anesthesia]. Based on my clinical assessment and review of their medical history, the patient is medically cleared for the procedure.

Relevant Medical History:
[List significant conditions, e.g., Hypertension, Diabetes, CAD]

Medication Instructions:

- **Anticoagulants/Antiplatelets:** [Hold/Continue] [Medication Name] starting [Number] days prior to procedure.
- **Diabetes Medications:** [Instructions for insulin or oral meds on day of prep/procedure].
- **Other Medications:** [Additional instructions].

Special Precautions:
[e.g., Cardiac clearance attached, Prophylactic antibiotics required, No specific precautions]

The patient is considered [ASA Class I/II/III]. If you have any further questions or require additional documentation, please contact my office.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[License Number]