

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Pre-Operative Medication Instructions for [Procedure Name] on [Surgery Date]

Dear [Patient Name],

Following your pre-operative clearance evaluation, this letter provides specific instructions regarding your current medications. To ensure your safety during surgery and minimize the risk of complications, please follow the schedule below:

### 1. Medications to STOP Taking

Medication Name	Stop Date (Days before surgery)	Last Dose Date
[e.g., Aspirin/NSAIDs]	[e.g., 7 days]	[Insert Date]
[e.g., Blood Thinners]	[e.g., 5 days]	[Insert Date]
[e.g., Diabetic Meds]	[e.g., Day of surgery]	[Insert Date]

### 2. Medications to CONTINUE Taking

- [Medication Name] - Take as usual, including the morning of surgery with a small sip of water.
- [Medication Name] - Take as usual.

### 3. Supplements and Vitamins

Please stop all herbal supplements, fish oils, and Vitamin E at least [Number] days prior to your procedure.

### Important Reminders

- Do not eat or drink anything after midnight the night before your surgery unless instructed otherwise.
- If you have any questions regarding these instructions, please contact our office at [Phone Number].
- Bring a complete list of your medications with you to the surgical center on the day of your procedure.

Failure to follow these medication instructions may result in the postponement or cancellation of your surgery.

Sincerely,

[Provider Name/Signature]

[Clinic/Department Name]

[Contact Information]