Date: [Date]

To: [Specialist Name or Facility Name]
Address: [Specialist Office Address]
Fax/Email: [Specialist Fax Number or Email]

RE: Pre-Operative Medical Records Request

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Scheduled Procedure: [Name of Surgery]
Date of Surgery: [Surgery Date]

Dear Medical Records Department,

The above-named patient is scheduled for surgery. To ensure a safe procedure and proper anesthesia management, we are requesting a formal pre-operative consultation and medical clearance from your office.

Please provide the following documentation:

- Recent consultation notes and clinical summaries
- Relevant diagnostic test results (EKG, Stress Test, Echo, Lab Work, etc.)
- Current medication list and dosage
- A formal statement regarding the patient's clinical stability for surgery

Please forward these records to [Requesting Surgeon/Physician Name] at:

Fax: [Your Fax Number]
Email: [Your Email Address]

Thank you for your prompt attention to this request to avoid any delays in the patient's surgical care.

Sincerely,

[Your Name/Signature]
[Your Title/Office Name]
[Your Phone Number]