Dear Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Re: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have seen the above patient for \_\_\_ sessions over the last \_\_\_ weeks for the above condition.

Following my clinical assessment, please find my recommendations of current functional abilities for this patient, which I suspect will be able to be further upgraded by \_\_\_\_\_\_\_\_\_\_\_(date).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physical function | Ability | | | Details  (frequency, duration, load, postures etc) |
| Can do | Can do with modification | Cannot |
| Sitting |  |  |  |  |
| Standing / walking |  |  |  |  |
| Kneeling / squatting |  |  |  |  |
| Carrying / holding / lifting |  |  |  |  |
| Reaching above shoulder |  |  |  |  |
| Bending |  |  |  |  |
| Use of affected body part |  |  |  |  |
| Neck movement |  |  |  |  |
| Climbing steps / stairs/ ladders |  |  |  |  |
| Driving |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

□ **In my opinion, recovery will be assisted by incorporating work to their current program.** (Check as appropriate)

Our management is focussed on

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_