Date: [Date]
Patient Name: [Patient Name]
Date of Birth: [DOB]
Referring Provider: [Referring Physician Name]

Dear [Referring Provider Name],

Thank you for referring [Patient Name] for an initial Geriatric Fall Risk Assessment. I evaluated the patient on [Date of Evaluation] to identify multifactorial risks for falls and to develop a personalized prevention strategy.

Clinical Findings:

- **Fall History:** [Number] falls in the past 12 months.
- **Gait and Balance:** [e.g., Timed Up and Go (TUG) score, Tinetti results, or observations].
- **Medical History:** [Relevant diagnoses such as Parkinson's, Neuropathy, Osteoporosis].
- **Medication Review:** [Identify high-risk medications such as benzodiazepines, antihypertensives, or polypharmacy].
- **Sensory/Cognitive Status:** [Vision, hearing, or MoCA/MMSE scores].

Assessment/Impression:

[Summarize risk level: Low, Moderate, or High risk for future falls].

Recommended Plan of Care:

- **Physical Therapy:** [Strength, gait training, and balance exercises].
- **Medication Adjustment:** [Recommended tapers or changes to address orthostatic hypotension or sedation].
- **Home Safety:** [Referral for Occupational Therapy or home safety evaluation].
- **Assistive Devices:** [Recommendation for cane, walker, or specialized footwear].
- **Supplements:** [Vitamin D and Calcium recommendations if appropriate].

I will follow up with the patient in [Time Frame] to monitor progress. Please feel free to contact my office at [Phone Number] if you have any questions.

Sincerely,

[Your Name/Signature]
[Your Title/Credentials]
[Practice Name]