Date: [Date]

To: [PCP Name]
Fax/Address: [PCP Fax or Address]

RE: Fall Risk Evaluation Report

Patient Name: [Patient Name]
Date of Birth: [DOB]

Dear Dr. [PCP Last Name],

I am writing to share the results of a formal fall risk evaluation conducted for our mutual patient on [Date of Assessment].

Evaluation Summary:

- **Screening Score:** [Insert Score, e.g., STEADI Score]
- **Risk Level:** [Low / Moderate / High]
- **Timed Up and Go (TUG) Test:** [Seconds]
- **30-Second Chair Stand:** [Number of Repetitions]
- **4-Stage Balance Test:** [Result/Time]

Key Findings and Deficits:

[Insert findings such as gait instability, orthostatic hypotension, vision impairment, or footwear issues]

Clinical Recommendations:

- [ ] Physical Therapy referral for strength and balance training
- [ ] Occupational Therapy referral for home safety assessment
- [ ] Medication review (potential polypharmacy/psychoactive meds)
- [ ] Vitamin D supplementation
- [ ] Vision/Optometry referral

The patient has been educated on fall prevention strategies and a follow-up plan has been established. Please include these findings in the patient's permanent medical record.

Sincerely,

[Your Name/Signature]
[Your Title/Credential]
[Your Clinic Name]
[Your Phone Number]