[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Dear [Patient Name],

This letter is to provide you with the results of your recent Fall Risk Assessment conducted on [Date of Assessment]. The purpose of this evaluation was to identify factors that may increase your risk of falling and to develop a plan to help maintain your safety and independence.

Assessment Findings

Based on our clinical evaluation and your medical history, your current fall risk level is categorized as: **[Low / Moderate / High]**.

Key factors contributing to this assessment include:

- [Factor 1: e.g., History of previous falls]
- [Factor 2: e.g., Balance or gait instability]
- [Factor 3: e.g., Medication side effects]
- [Factor 4: e.g., Vision or hearing changes]

Recommendations for Fall Prevention

To reduce your risk of injury, we recommend the following actions:

- **Physical Activity:** [e.g., Enroll in a balance or strength training program].
- **Home Safety:** [e.g., Remove loose rugs and improve lighting in hallways].
- **Medication Management:** [e.g., Review your current prescriptions with your pharmacist].
- **Assistive Devices:** [e.g., Use a cane or walker as instructed by your therapist].
- **Follow-up:** Schedule a follow-up appointment with [Provider/Department] in [Timeframe].

Safety is a collaborative effort. Please review these recommendations and contact our office at [Phone Number] if you have any questions or require assistance in implementing these changes.

Sincerely,

[Provider Name/Signature]
[Title/Credentials]
[Facility Name]