[Physician's Letterhead or Clinic Name]
[Address]
[Phone Number]
[Fax Number]

[Date]

To: [Assisted Living Facility Name]
Attention: Admissions/Nursing Department
[Facility Address]

RE: Fall Risk Clearance for [Patient Full Name]
Date of Birth: [Patient DOB]

To whom it may concern,

I have evaluated [Patient Name] on [Date of Evaluation] to assess their physical stability and risk for falls in an assisted living environment.

Based on my clinical examination, it is my professional opinion that the patient is cleared for residency at your facility. Please find the following clinical details regarding their mobility status:

- **Ambulation:** [Independent / Uses Walker / Uses Cane / Requires Assistance]
- **Transfer Status:** [Independent / Requires Minimal Assistance / Stand-by Assist]
- **Cognitive Status:** [Alert and Oriented / Mild Impairment / Memory Loss noted]
- **Balance/Gait:** [Steady / Unsteady / Compensated with Device]

Recommended Safety Measures:
[e.g., Physical therapy, non-slip footwear, bed rail use, or 2-hour safety checks]

I believe that with the appropriate level of care and the safety protocols provided by your facility, [Patient Name] can safely reside in an assisted living setting.

If you require further medical documentation or have questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]
[License Number]