[Date]

[Physician Name]
[Clinic/Facility Name]
[Address]
[City, State, Zip Code]

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

Dear Dr. [Physician Last Name],

I am writing to provide my formal recommendation regarding the mobility needs for our patient, [Patient Name]. Following a comprehensive physical therapy evaluation on [Date], I have determined that the patient requires a mobility device to improve safety, independence, and functional mobility.

Clinical Observations:
The patient presents with [list primary diagnosis or impairment, e.g., severe osteoarthritis, gait instability, or neurological deficit]. During the assessment, the patient demonstrated [describe findings, e.g., significant risk of falls, decreased weight-bearing tolerance, or limited endurance].

Recommended Device:
Based on these findings, I recommend the following: [Specific Device Name, e.g., Standard Manual Wheelchair, Front-Wheeled Walker, or Power Scooter].

Functional Justification:
The recommended device is medically necessary to allow the patient to perform Activities of Daily Living (ADLs) such as [list activities, e.g., toileting, dressing, or meal preparation]. Without this equipment, the patient is unable to safely ambulate within their home environment.

Please review these recommendations. If you agree, I have enclosed a detailed Certificate of Medical Necessity (CMN) for your signature. Please return the signed documentation to my office at your earliest convenience so we may proceed with the equipment order.

Thank you for your collaboration in this patient's care.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Credentials]
[Facility Name/Contact Information]