Date: [Insert Date]

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

To Whom It May Concern,

[Patient Name] has been diagnosed with a concussion (Mild Traumatic Brain Injury) and is currently under the care of a multidisciplinary clinical team. Based on our evaluation, the following treatment plan and restrictions are medically necessary to facilitate recovery.

1. Clinical Management Team

- **Primary Care/Sports Medicine:** [Provider Name]
- **Neurology:** [Provider Name]
- **Physical/Vestibular Therapy:** [Provider Name]
- **Neuropsychology/Mental Health:** [Provider Name]

2. Physical Activity Restrictions

The patient must adhere to a graduated return-to-play protocol. Currently, the patient is at the following stage:

- [ ] No physical activity; complete rest.
- [ ] Light aerobic exercise (walking, stationary bike) only.
- [ ] Sport-specific exercise without head impact.
- [ ] Non-contact training drills.
- **Prohibited:** Full contact, collision sports, or activities with high fall risk until cleared.

3. Academic/Work Accommodations

To manage cognitive load, the following accommodations are recommended:

- Shortened days or frequent rest breaks (15 minutes every hour).
- Reduced workload and extended deadlines for assignments.
- Avoidance of prolonged screen time (computers, tablets, phones).
- Testing in a quiet environment with 50% extra time.
- Exemption from standardized testing or high-stakes exams.

4. Therapeutic Interventions

The patient will participate in the following therapies:

- **Vestibular Therapy:** [Frequency] per week to address balance and dizziness.
- **Vision Therapy:** To address convergence insufficiency or tracking issues.

- **Exertion Therapy:** Monitored sub-symptom threshold exercise.
- **Cognitive Behavioral Therapy:** To manage post-concussive mood changes or sleep disturbances.

5. Follow-Up and Duration

The patient will be re-evaluated on [Follow-up Date]. These recommendations are in effect until [End Date] or until further notice from this office.

Sincerely,

[Signature]
[Provider Name, Credentials]
[Clinic Name]
[Phone Number]