

**Date:** [Insert Date]

**Subject:** Detailed Description of Daily Mobility Limitations

**To:** [Recipient Name/Organization]

**From:** [Your Full Name]

**Date of Birth:** [Your DOB]

**ID/Claim Number:** [Reference Number if applicable]

Dear [Recipient Name],

I am writing to provide a comprehensive description of the mobility limitations I experience on a daily basis due to [mention medical condition/diagnosis]. These physical restrictions significantly impact my ability to perform routine activities and maintain independence.

**1. Walking and Standing:**

I am unable to walk more than [Number] feet/meters without experiencing severe [pain/shortness of breath/fatigue]. I require the use of [cane/walker/wheelchair] for all distances. Standing is limited to [Number] minutes before I must sit down to rest.

**2. Navigating Stairs and Inclines:**

I am unable to climb stairs independently. Due to [joint instability/weakness], I must use a handrail and take one step at a time, or I am entirely restricted to using elevators and ramps.

**3. Transfers and Changing Positions:**

I experience significant difficulty transitioning from a seated to a standing position. Getting in and out of bed, a car, or a bathtub requires [physical assistance from another person/specialized equipment].

**4. Balance and Coordination:**

My balance is compromised, leading to a high risk of falls. I experience frequent dizziness or "giving out" of my [knees/ankles], necessitating constant supervision or the use of wall-mounting grab bars.

**5. Daily Living Impact:**

These limitations prevent me from performing essential tasks such as grocery shopping, cleaning, and personal hygiene without assistance. My range of motion in my [limbs/back] is restricted to the point that bending or reaching is painful and often impossible.

I am available to provide further medical documentation or undergo an evaluation to verify these limitations if required.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Phone Number]