

Date: [Insert Date]

Subject: Assessment of Cognitive and Physical Operation Capability

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Medical Record Number: [MRN Number]

To Whom It May Concern,

I am the primary healthcare provider for [Patient Name]. This letter provides a summary of the patient's current functional status regarding their cognitive and physical capabilities for [State Purpose, e.g., operating machinery, independent living, or returning to work].

1. Cognitive Functioning

Based on recent clinical evaluations and [Name of Tests, e.g., MMSE or MoCA], the patient demonstrates the following:

- **Memory:** [Intact / Impaired / Describe]
- **Executive Function:** [Ability to plan, organize, and follow multi-step instructions]
- **Alertness/Attention:** [Level of concentration and situational awareness]
- **Judgment:** [Capacity for safe decision-making]

2. Physical Operating Capability

Physical assessments indicate the patient's ability to perform motor tasks is as follows:

- **Motor Skills:** [Fine/gross motor control and coordination]
- **Strength and Range of Motion:** [Status of upper and lower extremities]
- **Vision and Hearing:** [Status of sensory inputs required for operation]
- **Reaction Time:** [Adequate / Delayed]

3. Clinical Conclusion

In my professional opinion, at this time, the patient is:

[] Capable of operating [Specific Equipment/Task] without restrictions.

[] Capable of operating [Specific Equipment/Task] with the following modifications: [Insert Requirements].

[] Not recommended for [Specific Task] due to [State Reason].

This assessment is based on the patient's current medical status and may be subject to re-evaluation if their condition changes.

Sincerely,

[Doctor Signature]

[Doctor Name, Credentials]

[Medical Facility Name]

[Phone Number]