Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Evaluation: [Date of Evaluation]

To Whom It May Concern,

This letter provides a summary of the current functional limitations and objective clinical measurements for the above-named patient regarding their [Specific Condition/Injury].

Objective Clinical Measurements

- **Range of Motion:** [Specify degrees or percentage compared to normal]
- **Strength Rating:** [Specify grade, e.g., 3/5 or MMT results]
- **Pain Scale:** [Score]/10 during [Specific Activity]
- **Balance/Stability:** [Result of standardized test, e.g., Berg Balance Scale]
- **Endurance:** [Specify time or distance before onset of fatigue/pain]

Current Functional Limitations

Based on the objective data above, the patient is currently unable to perform the following Activities of Daily Living (ADLs) or work-related tasks:

- **Mobility:** [e.g., Difficulty walking more than 50 feet without assistance]
- **Lifting/Carrying:** [e.g., Restricted to lifting no more than 5 lbs]
- **Postural Constraints:** [e.g., Unable to sit or stand for longer than 15 minutes]
- **Fine Motor Skills:** [e.g., Impaired ability to type or grasp small objects]
- **Self-Care:** [e.g., Requires assistance with dressing or bathing]

Clinical Assessment

[Insert brief professional opinion on how the measurements correlate to the limitations].

Sincerely,

[Signature]
[Name of Clinician/Provider]
[Title/Credentials]
[Facility Name]