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

To Whom It May Concern,

[Patient Name] was evaluated today on [Date] for an initial post-concussion assessment following a head injury. Based on the clinical examination and symptom report, the patient has been diagnosed with a concussion (Mild Traumatic Brain Injury).

Current Clinical Status:
The patient is currently experiencing symptoms which may include headache, dizziness, cognitive fatigue, and sensitivity to light/noise. Continued monitoring is required as these symptoms resolve.

Initial Recommendations:

- **Physical Rest:** Avoid strenuous physical activity, sports, or exercise until cleared by a medical professional.
- **Cognitive Rest:** Limit activities that require intense concentration (e.g., screen time, reading, video games).
- **Academic/Work Accommodations:** A gradual return to activities is recommended. The patient may require shortened days, frequent breaks, and extended time for tasks.

Follow-Up Plan:
The patient is scheduled for a follow-up evaluation on [Follow-up Date] to monitor progress and adjust the recovery plan. Formal clearance for return to full sports or unrestricted work will be determined at that time.

Please contact our office if you have any questions regarding these recommendations.

Sincerely,

[Provider Name/Signature]
[Provider Title]
[Clinic Name]
[Phone Number]