[Your Name, MD/DO]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

Social Security Administration
[Local Office Address]
[City, State, Zip Code]

RE: SSDI Support Letter for [Patient Name]
DOB: [Patient Date of Birth]
SSN: [Patient Last 4 Digits of SSN]

To Whom It May Concern:

I am a board-certified Orthopedic Surgeon currently treating [Patient Name] for [Primary Diagnosis/Conditions, e.g., severe osteoarthritis of the hip, degenerative disc disease]. I have been treating this patient since [Start Date] and have reviewed their full medical history, imaging reports, and clinical progress.

**Clinical Diagnosis and Findings:**
The patient presents with [List specific findings, e.g., spinal stenosis, joint space narrowing, herniated discs]. Objective medical evidence includes [List tests, e.g., MRI dated MM/DD/YYYY, X-ray dated MM/DD/YYYY, EMG findings].

**Functional Limitations:**
Due to these orthopedic conditions, the patient experiences the following functional limitations:

- Ability to stand/walk for only [Number] minutes at a time.
- Ability to sit for only [Number] minutes before requiring a change in position.
- Requirement of an assistive device ([Cane/Walker/Brace]) for ambulation.
- Significant restrictions in lifting, carrying, pushing, or pulling more than [Weight] pounds.
- Severe limitations in [reaching/bending/kneeling/crouching].

**Treatment and Prognosis:**
Treatment to date has included [List treatments: physical therapy, steroid injections, surgery, medications]. Despite these interventions, the patient continues to suffer from chronic pain and physical limitations. It is my professional medical opinion that these impairments are expected to last at least 12 months and prevent the patient from performing any sustained sedentary or physical work activity.

Please feel free to contact my office if further documentation is required.

Sincerely,

[Signature]

[Your Printed Name]
[Medical License Number]