

Date: [Date]

To: Social Security Administration

Re: Medical Support for Disability Claim

Claimant Name: [Patient Full Name]

Date of Birth: [Patient DOB]

SSN: [Patient SSN]

To Whom It May Concern,

I am writing this letter in support of [Patient Name]'s application for Social Security Disability Insurance (SSDI) benefits. I have been the treating neurologist for [Patient Name] since [Date].

Diagnosis and Clinical Findings:

The patient is diagnosed with [Specific Neurological Diagnosis, e.g., Multiple Sclerosis, Epilepsy, Parkinson's, Traumatic Brain Injury]. This diagnosis is confirmed by [Specific Tests, e.g., MRI, EEG, EMG, Lumbar Puncture] performed on [Date].

Symptoms and Functional Limitations:

[Patient Name] experiences the following symptoms which significantly impair their ability to function in a professional environment:

- **Motor Deficits:** [Describe weakness, paralysis, tremors, or loss of coordination].
- **Cognitive Impairment:** [Describe issues with memory, focus, processing speed, or executive function].
- **Sensory/Communication Issues:** [Describe speech difficulties, vision loss, or chronic neuropathy].
- **Fatigue/Seizures:** [Detail the frequency, duration, and post-event recovery time required].

Impact on Ability to Work:

Due to these impairments, the patient is unable to perform basic work-related activities, including:

- Maintaining a regular work schedule without excessive absences (estimated [Number] days per month).
- Staying on task for more than [Number] minutes at a time.
- Walking or standing for more than [Number] minutes.
- Lifting or carrying more than [Number] pounds.

Medical Opinion:

In my professional medical opinion, [Patient Name]'s condition meets or medically equals the criteria for Listing [Relevant Listing Number, e.g., 11.00 Neurological] in the SSA Blue Book.

The patient's limitations are expected to last for a continuous period of at least 12 months. Their neurological deficits make sustained, gainful employment impossible at this time.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]

[Medical Specialty/Title]

[Medical License Number]

[Clinic/Hospital Name]

[Phone Number]