

**Date:** [Insert Date]

**Patient Name:** [Insert Full Name]

**Date of Birth:** [Insert DOB]

**Patient ID/MRN:** [Insert ID Number]

**To:** [Insert Recipient Name/Organization]

**RE: Rheumatology Joint Function Assessment**

Dear [Insert Name],

This letter provides a clinical assessment of the above-named patient's joint function and musculoskeletal health following their evaluation at our Rheumatology clinic on [Insert Date of Exam].

**Clinical Diagnosis:**

[Insert Diagnosis, e.g., Rheumatoid Arthritis, Osteoarthritis, Psoriatic Arthritis]

**Functional Assessment Findings:**

- **Range of Motion (ROM):** [Insert details regarding limitations in specific joints]
- **Joint Inflammation:** [Insert findings regarding swelling, tenderness, or synovitis]
- **Grip Strength and Manual Dexterity:** [Insert observations or measurements]
- **Mobility and Gait:** [Insert assessment of walking and weight-bearing ability]

**Impact on Daily Activities:**

The patient's condition currently impacts their ability to perform the following tasks:  
[Insert specific limitations, e.g., lifting, prolonged standing, fine motor tasks]

**Current Treatment Plan:**

[Insert brief summary of medications, physical therapy, or scheduled interventions]

**Recommendations:**

[Insert workplace accommodations, assistive devices, or activity modifications]

Please contact our clinic at [Insert Phone Number] if further clarification is required.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Department of Rheumatology]

[Clinic/Hospital Name]