

Date: [Insert Date]

To: [Insurance Company/Social Security Administration Name]

Claim Number: [Insert Claim Number]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

Subject: Medical Statement Regarding Oncology Treatment and Prognosis

To Whom It May Concern,

I am writing this letter to support the disability claim for [Patient Name]. I am a board-certified Oncologist and have been treating the patient since [Start Date of Treatment] for [Specific Type/Stage of Cancer].

Clinical Diagnosis:

The patient has been diagnosed with [Detailed Diagnosis, including ICD-10 code and TNM staging]. This condition is characterized by [Briefly describe primary symptoms and tumor location].

Current Treatment Plan:

The patient is currently undergoing the following treatment regimen:

- **Chemotherapy:** [Drug names, frequency, and duration]
- **Radiation:** [Number of sessions and targeted area]
- **Surgical Intervention:** [Details of past or upcoming surgeries]
- **Other:** [Immunotherapy, hormone therapy, etc.]

Side Effects and Functional Limitations:

Due to the malignancy and the intensive nature of the treatment, the patient suffers from significant side effects including [List side effects: e.g., severe fatigue, cognitive impairment ("chemo-fog"), peripheral neuropathy, nausea, immunosuppression]. These complications prevent the patient from performing any substantial gainful activity or the requirements of their current occupation, specifically [List specific work restrictions, e.g., inability to stand for long periods, inability to concentrate, risk of infection in public settings].

Prognosis:

The patient's current prognosis is [Stable/Guarded/Poor]. Treatment is expected to continue for at least [Number] months/years. It is my medical opinion that the patient will be unable to return to work until at least [Estimated Date], at which time they will be reassessed.

Please contact my office at [Phone Number] if you require additional medical records or clarification regarding this claim.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]

[Medical Facility Name]

[Medical License Number]