

[Date]

To: [Recipient Name/Physician Name]

[Address]

[City, State, Zip Code]

Subject: Therapy Completion Letter - Activities of Daily Living (ADL)

Dear [Recipient Name],

This letter is to formally confirm that [Patient Name] (DOB: [Date of Birth]) has successfully completed their prescribed therapy program focused on Activities of Daily Living (ADL).

The patient was seen from [Start Date] to [End Date]. The primary goals of therapy were to improve independence in the following areas:

- Self-care (Dressing, bathing, grooming)
- Functional mobility and transfers
- Instrumental activities (Meal preparation, medication management)
- Safety awareness and use of adaptive equipment

At the time of discharge, the patient has met the following outcomes:

- [Outcome 1: e.g., Independent with lower body dressing]
- [Outcome 2: e.g., Improved safety during kitchen tasks]
- [Outcome 3: e.g., Proper use of walker and reacher tool]

The patient has been provided with a home exercise program and recommendations for continued safety. No further formal therapy is required at this time.

Sincerely,

[Your Name]

[Your Title/Credentials]

[Facility Name]

[Contact Information]