

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Date of Injury: [Insert Date of Injury]

To Whom It May Concern,

This letter serves as a follow-up regarding the post-concussion symptom evaluation for the above-named patient. The patient was evaluated on [Insert Evaluation Date] to monitor their recovery progress.

Current assessment of symptoms includes:

- Cognitive: [e.g., Difficulty concentrating, memory issues]
- Physical: [e.g., Headaches, dizziness, light sensitivity]
- Emotional: [e.g., Irritability, anxiety]
- Sleep: [e.g., Fatigue, insomnia]

Based on the clinical findings, the following recommendations have been made:

Status: [Choose: Improving / Stable / Persistent Symptoms]

Activity Restrictions:

[Insert specific restrictions regarding sports, work, or physical activity]

Academic/Work Accommodations:

[Insert specific needs such as reduced hours, frequent breaks, or extended testing time]

The patient is scheduled for a subsequent follow-up on [Insert Next Date]. If symptoms worsen or new neurological deficits emerge, please seek medical attention immediately.

Sincerely,

[Provider Name, Credentials]

[Clinic/Facility Name]

[Phone Number]