Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Date of Injury: [Insert Date of Injury]
Date of Assessment: [Insert Assessment Date]

Dear [Patient Name or Parent/Guardian],

This letter follows your recent concussion assessment at [Clinic Name]. Based on our evaluation, the following clinical findings and recovery plan have been established.

Clinical Assessment Summary:
[Insert brief summary of symptoms and physical exam findings]

Current Status:
[ ] Recovery is progressing as expected.
[ ] Symptoms persist; further intervention required.
[ ] Cleared for full return to activity/school/work.

Recommended Management Plan:

- **Physical Activity:** [Insert specific restrictions or step-wise return to play instructions]
- **Cognitive Rest:** [Insert school or work accommodations, e.g., reduced hours, no testing]
- **Medication:** [Insert any prescribed medications or OTC recommendations]

Follow-Up Requirements:
Your next follow-up appointment is scheduled for [Date/Time]. Please contact the clinic immediately if you experience worsening headaches, repeated vomiting, increased confusion, or seizures.

Provider Information:

[Signature]
[Provider Name, Title]
[Clinic Name]
[Phone Number]