[Physician or Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: Post-Concussion Cognitive Symptom Assessment
Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Injury: [Date of Injury]

To Whom It May Concern,

[Patient Name] is currently under my care for the management of a concussion sustained on [Date of Injury]. Based on my clinical evaluation and diagnostic assessment, the patient is experiencing significant cognitive symptoms consistent with Post-Concussion Syndrome.

The patient currently exhibits the following cognitive deficits:

- Difficulty with sustained attention and concentration
- Delayed processing speed
- Memory impairment (short-term and working memory)
- Increased mental fatigue following cognitive exertion
- Executive dysfunction (difficulty with planning and organization)

Due to these symptoms, I recommend the following temporary accommodations to support recovery:

- Reduced workload or shortened hours
- Frequent rest breaks during periods of high cognitive demand
- Extended time for tasks or examinations
- Minimization of environmental distractions (noise, bright lights)
- Avoidance of prolonged screen time

The patient will be re-evaluated on [Follow-up Date] to determine the progress of recovery and the necessity of continued accommodations. If you have any questions regarding this assessment, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Medical License Number]