Date: [Insert Date]

To: [Physician Name]
Fax/Address: [Physician Contact Information]

RE: Outpatient Physical Therapy Mobility Progress Report

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Diagnosis: [ICD-10 Code/Description]
Date of Evaluation/Start of Care: [Date]

Dear Dr. [Physician Last Name],

This letter is to provide an update regarding the patient's progress in outpatient physical therapy focusing on mobility and functional independence.

Current Status:
The patient has completed [Number] sessions to date. They are currently demonstrating [Improved/Stable/Declining] mobility levels.

Objective Functional Measures:

- Ambulation Distance: [e.g., 500 feet]
- Assistive Device: [e.g., Rolling walker, Cane, None]
- Gait Quality: [e.g., Improved cadence, reduced Trendelenburg]
- Balance Score (TUG/Berg): [Insert Score]
- Range of Motion/Strength: [Key Updates]

Clinical Assessment:
The patient is making [Steady/Minimal] progress toward established goals. Significant improvements have been noted in [List Specific Functional Task]. Barriers to progress include [List Barriers or "None"].

Plan of Care:
I recommend continuing physical therapy [Number] times per week for [Number] additional weeks to focus on [List Remaining Goals].

Please sign and return this form to authorize the updated Plan of Care.

Sincerely,

[Physical Therapist Name, Title]
[Facility Name]
[Phone Number]

Physician Certification:

I certify the medical necessity of continued physical therapy for this patient.

Physician Signature: _____ Date: _____