

**Date:** [Date]

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

Dear [Patient Name or Caregiver Name],

Thank you for completing your recent Fall Risk Assessment on [Date of Assessment]. The purpose of this evaluation was to identify factors that may increase your risk of falling and to develop a plan to help you maintain your independence and safety.

**Assessment Results:**

Based on our clinical evaluation and your performance on physical balance tests, your current fall risk is categorized as: [**Low / Moderate / High**].

**Key Findings:**

- **Balance and Mobility:** [Note findings, e.g., decreased steady gait, difficulty rising from chair]
- **Medication Review:** [Note if any medications affect dizziness or blood pressure]
- **Vision/Hearing:** [Note if updates to prescriptions are needed]
- **Environmental Factors:** [Note specific home hazards identified]

**Recommendations for Fall Prevention:**

1. **Physical Activity:** Participate in [Physical Therapy / Tai Chi / Strength Training] [Number] times per week to improve lower body strength.
2. **Home Safety:** Remove throw rugs, improve lighting in hallways, and install grab bars in the bathroom.
3. **Medication Management:** [Specific instructions regarding medication adjustments].
4. **Footwear:** Wear supportive, non-slip shoes both inside and outside the home.
5. **Follow-up:** Schedule a follow-up appointment in [Number] months to reassess progress.

Falling is not an inevitable part of aging. By following these recommendations, you can significantly reduce your risk of injury. Please contact our office at [Phone Number] if you have any questions or experience any new episodes of dizziness or imbalance.

Sincerely,

[Provider Name, Title]

[Clinic/Facility Name]