[Date]

[Referring Physician Name]
[Clinic/Practice Name]
[Address]
[City, State, Zip Code]

RE: [Patient Full Name]
DOB: [Patient Date of Birth]
Date of Evaluation: [Date]

Dear Dr. [Physician Last Name],

Thank you for referring [Patient Name] to [Your Facility Name] for physical therapy. I have completed the initial assessment regarding their [Condition/Reason for Referral].

Clinical Findings:
[Brief summary of examination, range of motion, strength, and functional limitations.]

Assessment:
[Physical therapy diagnosis and clinical impression.]

Plan of Care:
The patient will be seen [Number] times per week for [Number] weeks. Treatment will focus on [Primary Goals, e.g., pain reduction, gait training, therapeutic exercise].

I have attached the full evaluation report for your records. I will provide an update on the patient's progress at their next re-evaluation or upon discharge. Please contact me if you have any questions regarding this plan.

Sincerely,

[Your Signature]
[Your Printed Name], PT, DPT
[Your Phone Number]
[Your Email Address]