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Date

To Whom It May Concern;

Patient's name is a 9-year-old girl who receives weekly physical therapy at _____ for problems associated with her diagnosis of Left Hemiplegia Cerebral Palsy secondary to prematurity and a grade III IVH. Patient's name was discharged from physical therapy with a shift to only a home program. Patient's name plans to return to therapy during the summer break from school. Patient demonstrates a functional asymmetry, proximal muscle weakness, incomplete muscle gradation of her left side, joint and myofascial tissue restrictions on her left side, poor coordination of her left and right sides, and gait abnormalities. Patient underwent orthopedic surgery at _____ on_____ to correct tibial torsion and heelcord releases. She was casted for 6 weeks then placed in bilateral articulating AFOs that were fabricated by _____.

With the shift to a home exercise program patient would benefit from an adaptive mobility device that she could independently use to gain further strength, lower extremity joint mobility, coordination of her left and right sides and endurance. It is medically recommended that patient's name have an adaptive mobility device that would require her to utilize her LE muscles in a more active manner using an age appropriate piece of equipment. This mobility device, offered as a custom-built product, by Freedom Concepts would be an excellent choice for patient's home use. This device has been used for several months in her therapy program and patient has demonstrated safe independent usage. In addition to the medical needs being addressed, this device also promotes general fitness and offers patient's name an opportunity to interact with her peers thus improving her participation in age appropriate social activities. Please consider the purchase of a mobility device that would meet patient's name's medical needs at this time. See attached detailed specifications for the appropriate mobility device and medical prescription.

I can be contacted at _____ if you have any questions.

Thank you for this consideration,

Physician's name
Title/ Professional Designations
National Provider Identification Number