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SPILL THE TEA CAFE

CONFIDENTIAL

NAME OF RECIPIENT
RECIPIENT TITLE
RECIPIENT COMPANY
RECIPIENT ADDRESS
RECIPIENT CONTACT

DATE

SUBJECT: Medical Evaluation Letter for PATIENT INITIALS

To **[HONORIFIC]** NAME OF RECIPIENT /Whom It May Concern:

FULL LEGAL NAME (PREFERRED FIRST NAME) is currently under my medical care for treatment of a diagnosis as defined by the Diagnostic Statistical Manual-5-TR (DSM-5-TR). This diagnosis causes significant impairment in several areas of HONORIFIC. LAST NAME 's current functioning and meets the criteria of a disability.

I am familiar with HONORIFIC. LAST NAME 's medical history and the functional limitations imposed due to Diagnosis of DIAGNOSIS (ICD-10-CM CODE). Some of **PRONOUN** current symptoms: LIST PERTINENT SPECIFIC DIAGNOSIS SYMPTOMS HERE. These symptoms have recently been exacerbated by significant life stressors. Although the patient has been compliant in therapy, I feel **PRONOUN** might benefit from medication management in addition to talk therapy for DIAGNOSIS (ICD-10-CM CODE) symptoms.

Please feel free to contact me with any questions or concerns. I appreciate your collaboration and integrated behavioral health support of HONORIFIC. LAST NAME.

Thank you,
SEND OVER FOR SIGNATURE TO KIKI@SPILLTHETEACAFE.ORG

Haylin Dennison, LCSW
NPI #1215260278
License # 3914, HI
License issued: 12/16/2013
Expiration date: 6/30/2028
Phone: (808) 797-4970