Sample MD Letter for EDS Patient Disability Support

*Disclaimer: Template to be completed and customized for each patient case by your treating doctor without guarantee

[Your Name, MD]
[Your Medical Practice Name]
[Address] [City, State, Zip Code]
[Phone Number]

[Date]

The Honorable [Judge's Full Name] [Judge's Title] [Address] [City, State, Zip Code]

Re: [Patient's Full Name] – Disability Support Letter for Hypermobile Ehlers-Danlos Syndrome (hEDS)

Dear Judge [Last Name],

I am writing this letter on behalf of my patient, [Patient's Full Name], who has been under my care since [Date of First Consultation]. I am a board-certified medical doctor specializing in [Your Specialty], and I have extensive experience in treating patients with various connective tissue disorders, including hypermobile Ehlers-Danlos Syndrome (hEDS).

The purpose of this letter is to provide a detailed account of [Patient's Full Name]'s medical condition, as well as to outline the functional limitations and difficulties he/she/they experience in performing daily tasks and work-related duties. I hope this information will be valuable in determining [Patient's Full Name]'s eligibility for disability benefits.

Diagnosis and Medical History: [Patient's Full Name] was diagnosed with hypermobile Ehlers-Danlos Syndrome (hEDS) on [Date of Diagnosis]. hEDS is a rare genetic disorder characterized by joint hypermobility, musculoskeletal pain, and a range of systemic manifestations. Despite the implementation of various treatment plans, [Patient's Full Name]'s condition has continued to deteriorate, significantly affecting his/her/their quality of life.

Functional Limitations: In my professional opinion, [Patient's Full Name]'s hEDS has led to several significant functional limitations that restrict his/her/their ability to perform daily tasks and maintain gainful employment. These limitations include, but are not limited to: CUSTOMIZE THE BELOW SYMPTOMS AND FUNCTIONAL LIMITATIONS FOR EACH PATIENT AS BELOW IS A BROAD SAMPLE

1. Joint Instability: [Patient's Full Name] experiences frequent joint dislocations and subluxations, causing severe pain and mobility issues. This instability hinders his/her/their ability to perform tasks that require fine motor skills, such as typing or writing, as well as tasks that involve standing, walking, or lifting objects.
2. Chronic Pain: [Patient's Full Name] suffers from chronic pain as a result of joint dislocations, soft tissue injuries, and muscle strain. The pain is exacerbated by physical activity, making it difficult for him/her/them to maintain a consistent work schedule.

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3. Fatigue: hEDS is known to cause persistent fatigue, which impairs [Patient's Full Name]'s ability to concentrate, remember information, and complete tasks in a timely manner. The fatigue also affects his/her/their capacity to maintain a consistent work schedule.
4. Gastrointestinal Issues: [Patient's Full Name] experiences gastrointestinal complications, such as abdominal pain and irregular bowel movements, which can be disruptive and require frequent, unplanned breaks from work.
5. Autonomic Dysfunction: [Patient's Full Name] has symptoms of autonomic dysfunction, including dizziness, fainting, and temperature regulation issues, which further complicate his/her/their ability to perform work-related tasks safely and effectively.

Considering the severity of these limitations, it is my professional opinion that [Patient's Full Name] is unable to maintain gainful employment in any substantial capacity. The unpredictable nature of his/her/their symptoms makes it difficult for [Patient's Full Name] to commit to a consistent work schedule, and the physical demands of even sedentary jobs can exacerbate his/her/their pain and fatigue.

In conclusion, I respectfully request that you consider the information provided in this letter when evaluating [Patient's Full Name]'s application for disability benefits. I firmly believe that his/her/their medical condition warrants approval of the claim, as it severely impacts his/her/their ability to lead a normal life and maintain gainful employment. It is important to acknowledge that [Patient's Full Name] has tried various treatment options, including physical therapy, pain management, and lifestyle modifications, to alleviate the symptoms and improve his/her/their functional capacity. Despite these efforts, [Patient's Full Name] continues to struggle with the debilitating effects of hypermobile Ehlers-Danlos Syndrome.

Should you require any further information or clarification about [Patient's Full Name]'s medical condition, functional limitations, or treatment history, please do not hesitate to contact my office. I am more than willing to provide any additional documentation or testimony to support [Patient's Full Name]'s disability claim.

Thank you for your attention to this important matter. I trust that you will give [Patient's Full Name]'s case the thorough and compassionate consideration it deserves. Your assistance in helping [Patient's Full Name] receive the necessary disability benefits will be invaluable in ensuring his/her/their ongoing medical care and improving their quality of life.

Sincerely,

[Your Full Name, MD]
[Your Medical Practice Name]
[Your Credentials and Specialty]