You can us this letter to ask your healthcare professionals for information about your health. You can then use this evidence to support your Personal Independence Payment (PIP) claim. Where you see something written in red, it means you need to add or change something so that the letter is accurate for you.

Your address

Your date of birth

Date

Name and address of healthcare professional

Dear [add name]

I am making a claim for Personal Independence Payment (PIP) and am writing to ask if you would provide evidence to support my application.

To award PIP, the Department for Work and Pensions (DWP) needs to decide that I have limited ability to carry out certain activities to do with my daily living or mobility needs.

It has been shown that evidence from medical professionals can be extremely useful to help the DWP make appropriate decisions. Information from professionals can also help a decision to be made at the initial claim stage. This means that claimants may not need to go through a stressful appeal.

I would be very grateful if you could fill in this form [and send it back to me in the envelope provided] as I believe it will help my application.

Please be aware that I am not in a position to pay for any report or information. [delete if not applicable]

I would be grateful for any information you could provide.

Yours sincerely

Add your name

Please state what conditions I have, and what medications, treatments and therapies have been prescribed or recommended for me.

**When answering the following questions please consider my ability to perform each activity:**

* **safely;**
* **to an acceptable standard;**
* **repeatedly (as necessary); and**
* **within a reasonable time.**

**Please indicate where I am unable to perform these activities without either physical help, or someone prompting me to carry out the activities.**

1. To what extent do my condition(s) affect my ability to prepare food?
2. To what extent do my condition(s) affect my ability to take appropriate nutrition?
3. To what extent do my condition(s) affect my ability to manage therapy or monitor my health condition?
4. To what extent do my condition(s) affect my ability to wash or bathe?
5. To what extent do my condition(s) affect my ability to manage my toilet needs or incontinence?
6. To what extent do my condition(s) affect my ability to dress or undress?
7. To what extent do my condition(s) affect my ability to communicate verbally?
8. To what extent do my condition(s) affect my ability to read and understand signs symbols and words?
9. To what extent do my condition(s) affect my ability to engage with other people (who I both know and do not know) face to face?
10. To what extent do my condition(s) affect my ability to make budgeting decisions?
11. To what extent do my condition(s) affect my ability to plan and follow journeys (both those that are familiar and unfamiliar to me)?
12. To what extent do my condition(s) affect my ability to physically move around?

Signature Date Hospital/Surgery Stamp