[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Dear [Patient Name],

RE: Annual Geriatric Fall Risk Review Consultation

Our records indicate that it is time for your Annual Geriatric Fall Risk Review. As we age, maintaining balance and preventing falls is essential for staying independent and healthy.

During this consultation, we will perform the following:

- Review of your current medications and potential side effects.
- Assessment of your balance, gait, and muscle strength.
- Vision and hearing screening.
- Discussion of home safety and environmental hazards.
- Evaluation of footwear and assistive devices.

The goal of this visit is to create a personalized plan to reduce your risk of injury. Please bring all current medications (including over-the-counter vitamins and supplements) and the footwear you wear most often to this appointment.

Please call our office at [Phone Number] to schedule your appointment. If you have experienced a fall or felt unsteady since your last visit, please let us know when you call.

We look forward to seeing you soon.

Sincerely,

[Provider Name/Signature]
[Provider Title]