Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Discharge Summary: Food Allergy Desensitization Program

Dear Parent/Guardian and Primary Care Provider,

This letter confirms that **[Patient Name]** has successfully completed the active buildup phase of the Oral Immunotherapy (OIT) program for **[Allergen, e.g., Peanuts]**. The patient has reached the target maintenance dose of **[Dose Amount, e.g., 300mg]** of protein.

Maintenance Requirements

To maintain desensitization, the patient must follow these strict requirements:

- **Daily Dosing:** The patient must consume **[Dose Amount]** of **[Food Source]** every single day at approximately the same time.
- **Observation Period:** The patient must be supervised for at least [Number] hours after dosing.
- **Activity Restriction:** Avoid strenuous exercise, hot showers, or high heat for 2 hours after the dose.
- **Illness Protocol:** If the patient has a fever, vomiting, or respiratory distress, do not administer the dose and contact the clinic.

Emergency Protocol

The patient still has a diagnosed food allergy. In the event of an accidental ingestion or a systemic reaction to the dose:

1. Administer the Epinephrine Auto-Injector (EpiPen/Auvi-Q) immediately.
2. Call 911 or proceed to the nearest Emergency Room.
3. Contact our office once the patient is stable.

Follow-Up Care

The patient is scheduled for a follow-up appointment on **[Date]** at **[Time]**. We will continue to monitor the patient's progress and antibody levels periodically.

Sincerely,

[Physician Name, MD]
[Department of Allergy and Immunology]
[Clinic Name/Phone Number]