Date: [Date]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Treatment Period: [Start Date] to [End Date]

Dear [Patient Name/Parent Name],

This letter confirms that you have successfully completed your course of Sublingual Immunotherapy (SLIT) allergy drops for the treatment of [List Allergies, e.g., Grass Pollen, Dust Mites].

Over the past [Number] years of treatment, your immune system has been gradually desensitized to these specific allergens. Based on your final clinical review, you have reached the maintenance goal, and daily administration of the drops can now be discontinued.

Post-Treatment Instructions:

- **Symptom Monitoring:** While most patients maintain long-term relief, please monitor for any returning allergy symptoms over the next several months.
- **Rescue Medication:** You may still use standard antihistamines or nasal sprays on an as-needed basis if you experience environmental irritation.
- **Emergency Medication:** If you were prescribed an Epinephrine auto-injector for severe allergies, please consult with us regarding its ongoing necessity.

It has been a pleasure assisting you with your allergy management. If you experience a significant recurrence of symptoms in the future, please contact our office for a follow-up evaluation.

Sincerely,

[Physician Name]
[Clinic Name]
[Phone Number]