[Date]

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

Subject: Scheduled Medication Therapy Assessment

Dear [Patient Name],

This letter is to confirm your upcoming Medication Therapy Assessment with [Pharmacist/Provider Name]. This appointment is designed to review all your current medications, including prescriptions, over-the-counter drugs, and herbal supplements, to ensure they are safe and effective for you.

Appointment Details:

- **Date:** [Date of Appointment]
- **Time:** [Time]
- **Location:** [Clinic Name/Address or Telehealth Link]

Please prepare the following for your appointment:

- All your current medication bottles or a complete, updated list.
- Any questions or concerns you have regarding side effects or dosages.
- A list of any allergies to medications.

If you need to reschedule or cancel this appointment, please contact our office at [Phone Number] at least [Number] hours in advance.

We look forward to meeting with you and helping you manage your health.

Sincerely,

[Your Name/Signature]
[Title]
[Organization Name]