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

[Date]

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

Dear [Patient Name],

Our records show that you are due for your annual **Preventive Geriatric Fall Assessment**. As we age, maintaining balance and mobility is essential for staying independent and healthy.

During this brief appointment, your healthcare provider will:

- Review your current medications for side effects like dizziness.
- Evaluate your balance, strength, and gait.
- Discuss home safety and vision health.
- Provide a personalized plan to reduce your risk of falling.

Prevention is the best way to avoid serious injury. Please contact our office at [Phone Number] to schedule your assessment at your earliest convenience.

We look forward to seeing you soon.

Sincerely,

[Doctor/Provider Name]
[Clinic Name]