

## **URGENT: ANTICOAGULATION MONITORING REQUIRED**

Date: [Insert Date]

To: [Patient Name]

Address: [Patient Address]

Date of Birth: [Patient DOB]

Dear [Patient Name],

Our records indicate that your required blood test for anticoagulation therapy (Warfarin/INR or DOAC monitoring) is now overdue. Regular monitoring is essential to ensure your medication dose is safe and effective.

Failure to have this blood test may increase your risk of serious complications, including bleeding or blood clots. **For your safety, we may be unable to issue further prescriptions for this medication until this test is completed.**

### **Action Required:**

Please contact the clinic at [Phone Number] immediately to schedule your blood test or visit the laboratory at [Location] by [Insert Date].

If you have already had this test done in the last 48 hours, please disregard this letter.

Sincerely,

[Clinician Name/Department]

[Clinic/Hospital Name]

[Phone Number]