

## **URGENT: ACTION REQUIRED REGARDING YOUR MEDICATION**

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Patient ID: [Insert ID Number]

Dear [Insert Patient Name],

We are contacting you because your recent blood test (INR/PT) results dated [Insert Date of Test] show that your anticoagulation levels are within a **CRITICAL RANGE**. This means your blood is currently [too thin / too thick], which significantly increases your risk of [bleeding / blood clots].

### **REQUIRED ACTIONS:**

- **Contact our office immediately** at [Insert Phone Number] to speak with the anticoagulation nurse or your physician.
- Do NOT take your next dose of [Insert Medication Name, e.g., Warfarin] until you have spoken with a member of our medical team.
- If it is after business hours, please call [Insert After-Hours Number] or seek care at the nearest Emergency Department.

### **SEEK EMERGENCY CARE IMMEDIATELY IF YOU EXPERIENCE:**

- Uncontrolled bleeding or heavy nosebleeds.
- Blood in your urine or stool (black or tarry stools).
- Severe headache, dizziness, or sudden confusion.
- Sudden shortness of breath or chest pain.
- Pain, swelling, or redness in your leg.

Your safety is our priority. Please treat this notice with the highest urgency.

Sincerely,

[Insert Provider Name/Clinic Name]

[Insert Department Name]

[Insert Phone Number]