

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

[Date]

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

RE: URGENT: Mandatory Blood Test for Anticoagulation Medication

Dear [Patient Name],

Our records indicate that you are currently prescribed an anticoagulation (blood thinning) medication: **[Medication Name]**.

Because this is a high-risk medication, regular blood monitoring is essential to ensure your dose is safe and effective. According to our files, your monitoring is now overdue.

Required Action:

Please contact our office at [Phone Number] within the next [Number] days to schedule your blood test. If you have already had this test performed elsewhere recently, please let us know so we can update your records.

Why this is important:

Without regular monitoring, there is an increased risk of serious side effects, including internal bleeding or blood clots. For your safety, we may be unable to issue further repeat prescriptions for this medication until this check is completed.

If you have any questions or feel you have received this letter in error, please speak with our clinical team immediately.

Sincerely,

[Doctor/Provider Name]
[Practice Name]