[Your Name/Organization Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Recipient Name]
[Recipient Title/Role]
[Recipient Organization]
[Recipient Address]

RE: Treatment Plan Adjustment and Review
Patient Name: [Patient Name]
Date of Birth: [DOB]
Case Reference: [Reference Number]

Dear [Recipient Name],

Following the recent referral and specialist consultation conducted on [Date] with [Specialist Name], we have completed a comprehensive review of the findings and recommendations provided.

Based on the specialist's feedback and the patient's current clinical status, the following adjustments have been made to the primary treatment plan:

- **Adjustment 1:** [Description of change]
- **Adjustment 2:** [Description of change]
- **Medication Changes:** [List any new prescriptions or dosage updates]
- **Follow-up Schedule:** [New timeline for reviews]

The objective of these modifications is to [State goal, e.g., improve recovery speed, manage side effects, or address new symptoms identified during referral].

We request that you review these updates and integrate them into your records. Please confirm receipt of this adjustment and notify us if there are any conflicting clinical concerns regarding these changes.

The next formal review of this treatment plan is scheduled for [Date].

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title]