

[Clinic or Hospital Name]

[Address Line 1]

[Address Line 2]

[Phone Number]

Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

RE: IMPORTANT MEDICAL ALERT - CONFIRMED ALLERGY

Dear [Patient Name],

This letter is to formally document and notify you of a confirmed allergy identified during your recent clinical evaluation on [Date].

Our records have been updated to reflect the following allergy:

Allergen: [Name of Medication, Food, or Substance]

Reaction Type: [e.g., Anaphylaxis, Hives, Swelling, etc.]

Severity: [e.g., Mild, Moderate, or Life-Threatening]

For your safety, please follow these instructions:

- Inform all future healthcare providers (doctors, dentists, nurses) of this allergy before receiving treatment or prescriptions.
- Always check labels on over-the-counter medications and food packaging.
- [Optional: Carry an epinephrine auto-injector (EpiPen) at all times as prescribed.]
- [Optional: Consider wearing a medical alert bracelet or necklace.]

If you have any questions regarding this information or if you believe this record is in error, please contact our office immediately at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Name, Title]

[Department Name]