

# Medication Adjustment Notification

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Procedure: Endoscopy

Scheduled Date: [Insert Scheduled Date]

Dear [Patient's Name],

As you prepare for your upcoming endoscopy, we would like to inform you of important medication adjustments to ensure the safety and efficacy of the procedure. Please review the following instructions carefully:

## Medication Adjustments:

- **Anticoagulants:** Stop taking [Medication Name] [insert time frame, e.g., 5 days] prior to the procedure.
- **Diuretics:** Continue taking [Medication Name] but inform us of any changes in your kidney function.
- **Diabetes Medications:** Adjust [Medication Name] as follows: [Insert specific instructions].
- **Supplements:** Discontinue [Supplement Name] [insert time frame, e.g., 1 week] prior to the procedure.

Please contact our office if you have any questions or require additional information. It is vital that you follow these medication guidelines to ensure your safety during the endoscopy.

Thank you for your cooperation.

Sincerely,

[Your Name]

[Your Title]

[Your Contact Information]

[Medical Practice Name]