Appeal Against Changes in Medication Orders

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Title]

[Facility/Hospital Name]

[Address]

[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally appeal the recent changes made to my medication orders dated [insert date of changes]. I believe that these changes have not taken into consideration my medical history and current health conditions.

As a patient diagnosed with [insert specific conditions], my treatment plan has been carefully curated to align with my needs. The recent alterations have caused [insert specific issues or side effects], which have adversely affected my health and well-being.

I kindly request a review of my case and the decision regarding my medication. I believe it is imperative to revert to my previous orders that have proven to be effective in managing my health.

Thank you for your attention to this matter. I look forward to your prompt response and am hopeful for a positive resolution.

Sincerely,

[Your Name]

[Your Contact Information]

[Your Patient ID (if applicable)]