Your Institution's Header

DD-MM-YYYY

Institution Name
Institution Address

Dear Dr. *Healthcare Provider's Name,*

You are receiving this letter because your patient, *Patient's Full Name*, also receives care at our hemodialysis clinic at *Institution Name*. As part of a medication review, a shared decision was made with the patient to deprescribe the following medication(s):

- *Medication name, dose, and deprescribing plan*

The medication(s) listed above have limited evidence for use in patients on hemodialysis and may increase the risk of adverse events.

Once deprescribing is initiated, the patient will be monitored for medication-specific safety outcomes, symptom recurrence, and adverse events. If needed, the medication(s) may be restarted.

We are writing to inform you of this change and to support continuity of care. If you have any questions, concerns, or additional clinical information that may impact this plan, please do not hesitate to contact me.

Thank you for your collaboration in the care of this patient.

Best Regards,

Your Name and Credentials
Your Contact Information