Appendix A-7e: Nonadherence/Patient Unreachable

[Insert Health System Name]'s Pharmacist Atrial Fibrillation Medication Management Clinic

[Date]
[Name]
[Patient address]
[Patient City, State, Zip]

Dear [Patient name]:

We are the [Insert Health System name]'s Anticoagulation Management Service and [Insert Health System Name]'s Pharmacist Atrial Fibrillation Medication Management Clinic. You were referred to our clinic by your cardiologist [Insert name] for atrial fibrillation to help reduce your cardiovascular risk of heart attack and stroke.

We hope you are well. We have made several attempts to contact you by telephone and have been unsuccessful. Our clinic is a service provided to you in conjunction with our cardiologists and is dedicated to caring for patients with atrial fibrillation who require medications. We work with you to get some parameters, such as heart rates and oxygen levels using a pulse oximeter, that we evaluate and work alongside your doctor to make recommendations based on your physical condition and symptoms during exercise.

The purpose of our clinic is to keep your heart at goal, which in turn, would help you be symptom free and the way to check that is by having you perform a 6-Minute Walk Test every 3 to 6 months.

Please contact your clinician [Insert clinician name and telephone number] at your earliest convenience to continue with our rate control and anticoagulation management. We have also sent your doctor this letter to keep your care team informed. If you have another physician or Anticoagulation Management Service and Atrial Fibrillation Medication Management Clinic following your medications, please contact us and let us know so that we may update our records and remove you from our patient roster.

We hope to continue to work with you to help reduce your cardiovascular risk of heart attack and stroke. Regrettably, failure to call us before (one month from date of letter generation) will result in termination from our service.

Thank you for your time,

_____
[Insert Name, credentials]
[Insert title]
[Insert Health System Name]'*s* Anticoagulation Service
[Insert telephone number]
[Insert email]

cc: [Insert referring MD]