PATIENT NAME DATE LETTER SENT
PATIENT ADDRESS
CITY, STATE 99999

Dear Mr./Ms:

(Enter your facility name here)is interested in the health and well-being of its patients long after their encounter with our hospital/clinic. We would appreciate if you would take a moment to complete the brief questionnaire below so we can update our records. Your response will be kept strictly confidential.

If you received this form in error, please let us know this also. In doing so we will update our record and remove you from our mailing list.

Thank you for your assistance and prompt reply. A self-addressed, stamped envelope is provided for your assistance.

Sincerely,

Name of contact
Follow Up Coordinator
Phone number of contact

Has your address or phone number changed? Please provide any new information.

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____) _____-_____

What is your present health? Excellent____ Good _____ Fair____ Poor____
Physician now caring for you:

Dr.:_____
City/State:_____

Date of last exam: ____/____/____

Is there someone we may contact if we are unable to reach you? Yes___ No___

Name:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____) ____-____

SECONDARY CONTACT'S NAME (Must be an authorized contact only) DATE LETTER SENT
ADDRESS
CITY, STATE 99999

Dear Mr./Ms:

The staff at (enter your hospital name) are interested in the health and well-being of its patients long after their encounter with our hospital/clinic. Unfortunately, we have not been able to contact:

NAME OF PATIENT

If you have any knowledge of the whereabouts of this patient, we would appreciate if you would complete the information below and return to us in the enclosed return-addressed envelope. Please be assured that all the information you provide will be kept strictly confidential.

If you received this form in error, please let us know this also. In doing so we will update our record and remove you from our mailing list.

Thank you for your assistance and prompt reply.

Sincerely,

Name of contact and title
Name of your facility
Follow Up Coordinator
Phone number

Please provide information on: Patient Name

Current Address: _____

City: _____ State:_____ Zip:_____ Phone: (____) _____-_____

Patient's current condition(if known): Doing well____ Not doing well____

Comments (if any):_____

_____