

[Hospital/Clinic Name]  
[Department Name]  
[Address Line 1]  
[City, State, Zip Code]  
[Phone Number]

[Date]

[Patient Name]  
[Patient Address]  
[City, State, Zip Code]

Dear [Patient Name],

**Subject: Mandatory Post-Surgical Follow-Up Assessment**

Our records indicate that you were recently discharged following your surgical procedure on [Date of Surgery]. As part of your post-operative care plan, it is necessary for you to attend a follow-up assessment to monitor your recovery and ensure proper healing.

Your appointment has been scheduled for:

**Date:** [Appointment Date]  
**Time:** [Appointment Time]  
**Location:** [Clinic/Building Name, Room Number]  
**Provider:** [Doctor/Surgeon Name]

Please bring a list of any medications you are currently taking and any specific questions you may have regarding your recovery. If you have experienced increased pain, redness at the incision site, or fever, please contact our office immediately prior to this appointment.

If you need to reschedule or cannot attend this appointment, please call us at [Phone Number] at least 24 hours in advance.

We look forward to seeing you and assisting with your continued recovery.

Sincerely,

[Your Name/Signature]  
[Your Title/Position]  
[Department Name]