



**Sunshine Coast University
Private Hospital**
Part of Ramsay Health Care

**Post Discharge Readmission/
Complication Notification**

OQ: _____
 Surname: _____
 Given Name: _____
 DOB: _____ Sex: _____
(please affix Patient Identification label here, if available)

This is a courtesy correspondence to notify your facility that post discharge

Mr/Mrs/Ms/Dr: _____

Date of Birth: _____

was re-admitted to another facility
 Facility name: _____

Developed a complication

Deceased

Additional Details

BINDING MARGIN - DO NOT WRITE

Is a clinical review is suggested? Yes No

Details of review requested

Kind regards;

Attending VMO name _____

Signature _____

Please email to slaterd@ramsayhealth.com.au or fax to 07 5390 6001.