

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert Date of Birth]

**Patient ID/MRN:** [Insert ID Number]

**From:** [Referring Provider Name/Clinic]

**To:** [Receiving Provider Name/Clinic]

---

**Subject: Primary Reason for Transfer of Care**

Dear [Receiving Provider Name],

I am writing to formally transfer the medical care of the above-named patient to your practice.

**Primary Reason for Transfer:**

[Insert specific reason, e.g., Patient relocation, Requirement for specialized cardiac intervention, Insurance network change, Transition from pediatric to adult care, or Patient request for second opinion.]

**Clinical Summary:**

The patient is currently being treated for [List primary diagnosis]. The goal of this transfer is to ensure [Insert goal, e.g., continuity of maintenance therapy or access to advanced surgical facilities].

**Key Documentation Attached:**

- Recent Clinical Notes
- Current Medication List
- Relevant Lab Results and Imaging Reports
- Immunization Records

The patient's last visit with this office was on [Date]. Their next required follow-up is recommended for [Date/Timeframe].

Please contact our office at [Phone Number] if you require additional information regarding this transition.

Sincerely,

[Your Signature]

[Your Printed Name and Title]

[Clinic Name]