

Date: [Date of Transfer]

To: Receiving Facility Name

Department: [Receiving Department]

Attending Physician: [Name of Receiving Physician]

PATIENT INFORMATION

Patient Name: [Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Gender: [Gender]

ENCOUNTER SUMMARY

Date of Admission: [Admission Date]

Reason for Transfer: [e.g., Escalation of care, specialized surgery, proximity to home]

Primary Diagnosis: [Principal Medical Diagnosis]

Secondary Diagnoses: [List of comorbidities]

CLINICAL COURSE & TREATMENT

Hospital Course: [Brief summary of procedures, stabilization, and progress]

Recent Vital Signs: [BP, HR, RR, Temp, SpO2]

Last Dose of Medication: [List critical medications and time administered]

Allergies: [List allergies or "No Known Drug Allergies"]

TRANSFER STATUS

Code Status: [Full Code / DNR / DNI]

Dietary Status: [NPO / Specific Diet]

Infection Control: [Standard Precautions / Contact / Droplet / Airborne]

Nursing/Mobility Needs: [Weight bearing status, assistance required]

PENDING RESULTS & FOLLOW-UP

Pending Lab/Imaging: [List tests awaiting results]

Recommended Next Steps: [Urgent interventions or consultations required upon arrival]

Sending Provider: [Name and Title]

Sending Facility: [Facility Name]

Contact Number: [Direct Phone/Pager Number]

Signature: _____