Date: [Date]

RE: Transfer Discharge Summary

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Admission Date: [Date]
Discharge/Transfer Date: [Date]

Receiving Facility: [Name of Receiving Institution]
Receiving Physician: [Name of Physician, if known]

1. Final Diagnoses:
[Primary Psychiatric Diagnosis]
[Secondary/Medical Diagnoses]

2. Reason for Transfer:
[Reason: e.g., Need for long-term stabilization, medical necessity, patient request, or specialized care]

3. Clinical Summary:
[Brief overview of hospital course, behavioral updates, and response to treatment]

4. Risk Assessment:
Suicidality: [Low/Medium/High/None]
Homicidality/Aggression: [Low/Medium/High/None]
Precautions: [e.g., 15-minute checks, elopement risk]

5. Current Medications:
[List medication name, dosage, frequency, and last dose administered]

6. Labs and Pertinent Test Results:
[List recent lab work, toxicology, or imaging results]

7. Legal Status:
[Voluntary / Involuntary / Legal Guardian Information]

8. Discharge Instructions/Plan of Care:
[Specific instructions for the receiving facility]

Physician Signature: ________________________
Printed Name: [Provider Name]
Contact Number: [Phone Number]