

**Date:** [Date]

**To:** [PCP Name]

**Clinic Name:** [Clinic Name]

**Address:** [PCP Address]

**RE: Discharge Summary and Transfer of Care**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Admission Date:** [Start Date]

**Discharge Date:** [End Date]

Dear Dr. [PCP Last Name],

This letter is to formally transfer the primary care of the above-named patient back to your office following their stay at [Rehabilitation Facility Name]. The patient was admitted for sub-acute rehabilitation following [Primary Diagnosis/Surgery].

**Clinical Summary:**

During their stay, the patient received [Physical/Occupational/Speech] therapy. At the time of discharge, the patient has reached the following functional status: [Brief Status Update].

**Medication Changes:**

Please note the following adjustments made to the patient's medication regimen:

- [Added/Discontinued Medication Name]
- [Added/Discontinued Medication Name]

A complete updated medication list is attached to this record.

**Pending Lab Results/Tests:**

[List any pending results or "None"]

**Follow-Up Requirements:**

The patient has been instructed to schedule a follow-up appointment with your office within [Number] days. They also have scheduled appointments with the following specialists:

- [Specialist Name] on [Date]

Home health services have been arranged for: [Services Provided].

Thank you for your continued care of this patient. Please contact our facility at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Doctor/Case Manager Signature]  
[Typed Name and Title]  
[Facility Name]