Date: [Insert Date]

To: [Hospice Name / Admissions Department]
Address: [Hospice Address]
Phone: [Hospice Phone Number]
Fax: [Hospice Fax Number]

RE: Patient Transfer and Referral

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Address: [Patient Address]
Next of Kin / Proxy: [Name and Phone Number]

Dear Admissions Team,

This letter serves to formally transfer the care of the above-named patient from [Clinic Name] to [Hospice Name] for end-of-life care and symptom management.

Primary Diagnosis: [Insert Primary Terminal Diagnosis]
Secondary Diagnoses: [Insert Relevant Comorbidities]

Clinical Summary:
The patient has a life expectancy of six months or less if the disease runs its normal course. The patient and their family have been counselled regarding the transition from curative to palliative goals. They have expressed a desire to focus on comfort, quality of life, and pain management.

Current Medications:
[List medications or attach Medication Administration Record]

Allergies: [List Allergies]

Advanced Directives:
The patient currently has the following in place: [DNR / DNI / Full Code / POLST Form Attached].

Please find the attached medical records, recent lab results, and signed hospice election forms for your review. If you require further clinical information, please contact our office at [Clinic Phone Number].

Thank you for coordinating the care for this patient.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Clinic Name]
[NPI Number]