Date: [Date]

To: [Primary Care Physician Name / Receiving Facility Name]
Address: [Address]
Phone: [Phone Number]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

Discharge Summary and Transition Plan

Diagnosis and Reason for Palliative Consultation:
[Insert primary life-limiting illness and main symptoms managed]

Goals of Care and Advanced Directives:
[Current Code Status: Full Code / DNR / DNI / DNH]
[Summary of patient/family goals: e.g., comfort focus, remaining at home, or aggressive intervention]

Symptom Management Plan:

- **Pain Control:** [Medication, dosage, and frequency]
- **Respiratory:** [Oxygen needs or medications for dyspnea]
- **Gastrointestinal:** [Nausea or bowel regimen]
- **Anxiety/Delirium:** [Medication or behavioral interventions]

Medication Changes:
[List medications started, stopped, or adjusted during this transition]

Follow-Up and Community Support:

- **Home Health / Hospice Agency:** [Agency Name and Contact Info]
- **Equipment Delivered:** [e.g., Hospital bed, oxygen, suction]
- **Next Appointment:** [Date and Time with PCP or Specialist]

Emergency Contact Information:
[Name of Primary Caregiver] - [Phone Number]

Sincerely,

[Signature]
[Printed Name and Title]
[Palliative Care Team/Hospital Name]
[Contact Phone Number]