Date: [Insert Date]

To: Admitting Physician / Intake Coordinator
Facility: [Hospice Facility Name]
Address: [Facility Address]

RE: Patient Transfer

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

Dear Intake Team,

This letter serves to formally transfer the care of the above-named patient from [Clinic Name] to [Hospice Facility Name] for inpatient hospice care.

Primary Diagnosis: [Insert Terminal Illness/Diagnosis]

Clinical Summary:
The patient has been under our care for [Duration]. Due to [Reason for Transfer: e.g., uncontrolled symptoms, decline in functional status, caregiver burnout], the patient now requires 24-hour skilled nursing care and symptom management consistent with inpatient hospice criteria.

Current Goals of Care:
The patient and family have elected for a comfort-oriented approach. Current code status is [DNR/DNI or Full Code].

Key Symptoms for Management:
[List symptoms, e.g., intractable pain, dyspnea, terminal agitation]

Current Medications:
[List medications or refer to attached medication list]

Attachments included:
- Recent clinical notes
- Current medication list
- Advance Directives / POLST form
- Recent lab results and imaging

I will remain available for any questions regarding the patient's history prior to this transfer.

Sincerely,

[Physician Signature]
[Physician Name, Title]

[Clinic Name]
[Phone Number]