Date: [Date]

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

To: [Hospice Agency Name / Primary Care Physician]

RE: Discharge to Home Hospice Care

This letter serves as formal notification that the above-named patient is being discharged from [Clinic Name] to Home Hospice care effective [Date].

Primary Diagnosis:
[Insert Terminal Diagnosis]

Clinical Summary:
[Brief description of patient status and reason for transition to palliative goals].

Current Medications:

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

Comfort Measures & Orders:

- DNR/DNI status confirmed: [Yes/No]
- Oxygen: [Liters per minute/As needed]
- Pain Management: [Specific instructions]

Durable Medical Equipment (DME) Arranged:
[List equipment e.g., hospital bed, commode, nebulizer]

Point of Contact:
The patient's care will now be managed by [Hospice Agency Name] at [Phone Number]. For any clinical questions regarding the transition, please contact our office at [Clinic Phone Number].

Sincerely,

[Doctor Name, MD/DO]
[Clinic Name]
[Phone Number]