Date: [Insert Date]

From:
[Sending Physician/Provider Name]
[Facility Name]
[Phone Number]

To:
[Receiving Physician/Hospice Agency Name]
[Facility Name/Address]
[Phone Number]

RE: Patient Transfer for End-of-Life/Palliative Care

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

Dear [Receiving Provider Name],

This letter serves to formally transfer the care of the above-named patient for transition to [Hospice Care / Comfort Care / Palliative Inpatient Care].

Diagnosis and Clinical Summary:
The patient has been diagnosed with [Primary Diagnosis]. Despite therapeutic interventions, the clinical status has declined. The goals of care have been transitioned to focus on comfort, symptom management, and quality of life.

Current Symptom Management:
The patient is currently experiencing [List symptoms, e.g., pain, dyspnea, agitation]. Current medications for comfort include:
[List Medications and Dosages]

Advance Directives and Legal Status:
- Resuscitation Status: [e.g., DNR/DNI or Full Code]
- Health Care Proxy/Next of Kin: [Name and Phone Number]
- Advance Directive/POLST: [Attached/Not Attached]

Transfer Requirements:
- Mode of Transport: [e.g., Ambulance/Stretcher]
- Oxygen Needs: [e.g., 2L via Nasal Cannula]
- Special Equipment: [e.g., Hospital bed, Suction]

Discharge/Transfer Orders:
All relevant medical records, medication administration records, and signed transition orders are attached to this document.

Please contact me at [Phone Number] if you require further clinical clarification during this transition.

Sincerely,

[Signature]
[Printed Name and Credentials]
[Facility/Department]