Date: [Insert Date]

To: [Receiving Provider Name/Facility]
Address: [Provider Address]
Fax/Phone: [Provider Contact Info]

RE: Transfer of Care / Discharge Summary

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Admission Date: [Start Date]
Discharge Date: [End Date]

Diagnosis:
[Primary Substance Use Disorder Diagnosis and any Co-occurring Disorders]

Reason for Discharge:
[Successful Completion / Transfer to Higher Level of Care / At Administrative Discharge / AMA]

Summary of Treatment:
[Brief description of interventions, therapies, and patient progress during the program.]

Current Medications:
[List medication names, dosages, and frequencies, or state "None"]

Toxicology Results:
[Summary of final drug screen results]

Discharge Plan & Recommendations:
[Outline follow-up appointments, recommended support groups like AA/NA, and specific continuing care instructions.]

Risk Assessment:
[Status of suicide/homicide risk and relapse potential at time of discharge]

Sincerely,

[Provider Signature]
[Provider Printed Name and Credentials]
[Clinic Name]
[Phone Number]