URGENT MEDICAL CLINIC TRANSFER DISCHARGE LETTER

Date: [Insert Date]

To: Admitting Physician / Nursing Director
Facility Name: [Insert Receiving Geriatric Facility Name]
Facility Address: [Insert Facility Address]

PATIENT INFORMATION
Name: [Patient Full Name]
Date of Birth: [DOB]
ID/Medical Record Number: [ID Number]
Emergency Contact: [Name and Phone Number]

CLINICAL SUMMARY
Date of Admission to Clinic: [Start Date/Time]
Reason for Visit: [Primary Complaint/Symptoms]
Diagnosis: [Primary Diagnosis and Secondary Findings]

TREATMENT PROVIDED
Procedures/Interventions: [List tests, IV fluids, or procedures performed]
Medications Administered: [List drug name, dosage, and time given]

CURRENT STATUS AT TRANSFER
Vital Signs: BP: [Value], HR: [Value], Temp: [Value], SpO2: [Value]
Mental Status: [e.g., Alert, Oriented, Confused, Baseline for Patient]
Mobility: [e.g., Bed bound, Assist of 1, Independent]

TRANSFER ORDERS & RECOMMENDATIONS
Follow-up Care: [List required monitoring or wound care]
Medication Changes: [List new prescriptions or discontinued meds]
Pending Results: [List any labs or imaging results still awaited]

PHYSICIAN SIGNATURE

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Name: [Provider Name, Title]
Clinic Name: [Urgent Care Name]
Contact Phone: [Phone Number]