Date: [Date of Transfer]

To: [Receiving Facility Name/Emergency Department]
Attention: Admitting Nurse / Attending Physician

RE: Patient Transfer/Discharge Notice

Patient Name: [Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Social Security Number: [SSN - Optional]

Reason for Transfer:
[e.g., Acute change in condition, higher level of care required, scheduled discharge to home/assisted living]

Primary Diagnoses:
[List major medical conditions and comorbidities]

Vital Signs at Time of Transfer:
BP: [00/00] | HR: [00] | RR: [00] | Temp: [00.0] | SpO2: [00%] on [Room Air/Oxygen Amount]

Mental Status / Baseline:
[e.g., Alert and oriented x3, baseline dementia, non-verbal]

Code Status: [DNR / DNI / Full Code]

Allergies: [List allergies or NKA]

Functional Status:
Mobility: [e.g., Bed bound, assists with 1, independent]
Diet: [e.g., Regular, Mechanical Soft, NPO]
Skin Condition: [e.g., Intact, Stage 2 pressure ulcer on coccyx]

Nursing Summary:
[Brief description of recent events leading to transfer]

Attached Documentation:
[ ] Medication Administration Record (MAR)
[ ] Recent Lab Results / Imaging
[ ] Physician Transfer Orders
[ ] Advance Directives / Power of Attorney
[ ] Personal Belongings Inventory

Facility Contact Information:
Sending Facility: [Name of Skilled Nursing Facility]

Unit Phone Number: [Phone Number]
Transferring Nurse: [Name and Title]

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Signature of Sending Clinician