

Date: [Insert Date]

TO: [Receiving Facility Name]

ATTN: Admissions Department / Nursing Station

FROM: [Sending Facility Name]

RE: Transfer of [Patient Full Name]

1. PATIENT IDENTIFICATION

Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Surrogate/Next of Kin: [Name and Phone Number]

2. DISCHARGE DIAGNOSES

Primary Reason for Rehab: [e.g., Status post Right Hip Open Reduction Internal Fixation]

Secondary Diagnoses: [e.g., Hypertension, Type 2 Diabetes, Mild Cognitive Impairment]

3. CLINICAL SUMMARY

Hospital Course: [Brief summary of treatment and progress made during stay].

Vitals at Discharge: BP: [BP], HR: [HR], Temp: [Temp], O2 Sat: [O2] on [Room Air/Amount of Oxygen].

Last Bowel Movement: [Date/Time].

4. FUNCTIONAL STATUS & THERAPY

Mobility: [e.g., Ambulates 50ft with rolling walker and contact guard assist]

Transfers: [e.g., Modified Independent / Minimal Assist]

ADLs: [e.g., Requires setup for dressing and bathing]

Weight Bearing Status: [e.g., Full Weight Bearing / Non-Weight Bearing Left Leg]

5. MEDICATIONS & ORDERS

Current Medications: See attached Medication Administration Record (MAR).

Last Dose of Anticoagulant: [Drug Name, Dose, and Time given].

Last Dose of Opioid Pain Med: [Drug Name, Dose, and Time given].

Pending Lab Results: [List any outstanding tests].

6. NURSING & SKIN CARE

Skin Condition: [e.g., Intact / Stage 2 Pressure Injury on Coccyx]

Wound Care: [Instructions for dressing changes]

Diet: [e.g., Regular / Mechanical Soft / Thickened Liquids]

Allergies: [List Allergies]

7. FOLLOW-UP APPOINTMENTS

- **Specialty:** [e.g., Orthopedics] - **Date:** [Date] - **Time:** [Time]
- **Specialty:** [e.g., Cardiology] - **Date:** [Date] - **Time:** [Time]

8. CONTACT INFORMATION

For clinical clarification regarding this transfer, please contact:

Discharging Physician/Provider: [Name] at [Phone Number]

Discharging Nurse: [Name] at [Phone Number]

Signature of Discharging Clinician