Date: [Date]

To: [Receiving Facility Name/Attending Physician]
Address: [Facility Address]

RE: Palliative Care Transfer Discharge Letter

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Admission Date: [Date]
Discharge/Transfer Date: [Date]

1. Principal Diagnosis and Clinical Summary:
[Brief description of primary life-limiting illness, comorbid conditions, and reason for transfer to geriatric facility.]

2. Goals of Care and Advanced Directives:
Code Status: [e.g., DNR/DNI/Comfort Measures Only]
Surrogate Decision Maker: [Name and Contact Information]
Summary of Goals: [e.g., Pain management, symptom control, quality of life.]

3. Current Medication List:
[List medication name, dosage, frequency, and route. Highlight PRN medications for breakthrough pain/anxiety.]

4. Symptom Management Status:
Pain: [Current level and management plan]
Respiratory: [Oxygen needs or dyspnea management]
Psychosocial/Agitation: [Current status and interventions]

5. Functional Status and Nursing Needs:
Mobility: [e.g., Bedbound, assist of 1, etc.]
Nutrition: [e.g., Oral intake as tolerated, thickened liquids, etc.]
Skin Care: [e.g., Pressure ulcer staging or wound care instructions]

6. Follow-up and Contact Information:
In the event of clinical decline or questions regarding the palliative plan, please contact:
Referring Physician: [Name/Phone]
Palliative Care Team: [Contact Info]

Sincerely,

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