Date: [Date of Transfer]

TO: [Receiving Facility Name]
ATTENTION: Admissions Department / Nursing Supervisor
FROM: [Sending Facility Name]

PATIENT IDENTIFICATION

Patient Name: [Full Name]
Date of Birth: [DOB]
Gender: [Gender]
Medical Record Number: [MRN]
Insurance Info: [Provider and Group Number]

REASON FOR TRANSFER

[Reason: e.g., Change in level of care, acute medical necessity, family request, or permanent relocation.]

MEDICAL SUMMARY

Primary Diagnosis: [Primary Diagnosis]
Secondary Diagnoses: [Dementia, Hypertension, Diabetes, etc.]
History of Present Illness: [Brief summary of recent clinical status and treatment at current facility.]

CURRENT STATUS

- **Code Status:** [DNR/DNI/Full Code]
- **Mental Status:** [Alert/Oriented, Confused, Non-verbal]
- **Mobility:** [Ambulatory, Assist of 1, Bedbound]
- **Diet:** [Regular, Pureed, NPO, Thickened Liquids]
- **Skin Condition:** [Intact, Pressure Ulcers (Stage/Location)]

MEDICATIONS AND ALLERGIES

Allergies: [List all allergies or NKA]

Current Medications: [See attached Medication Administration Record (MAR)]

NURSING AND REHABILITATION NEEDS

Special Equipment: [Oxygen, CPAP, Feeding Tube, Catheter, Wound Vac]
Physical/Occupational Therapy: [Last session date and current goals]

CONTACT INFORMATION

Primary Family Contact: [Name and Phone Number]
Power of Attorney (POA): [Name and Phone Number]

Transferring Physician/Provider: [Provider Name]
Facility Phone Number: [Phone Number]

_____
Signature of Discharging Clinician

Attachments: MAR, Most Recent Labs, History and Physical, Immunization Record, Advance Directives.