

Date: [Date]

To: [Receiving Facility Name/Hospital Name]

Attention: [Admissions Department/Nursing Station]

Address: [Facility Address]

RE: Transfer/Discharge of [Resident Full Name]

Date of Birth: [DOB]

Social Security Number: [Last 4 Digits]

To Whom It May Concern,

Please be advised that [Resident Name] is being transferred from [Current Facility Name] to [Receiving Facility Name] effective [Transfer Date].

Reason for Transfer:

[Insert Reason: e.g., Change in level of care, acute medical emergency, family request, or permanent discharge].

Current Medical Status:

[Brief summary of current condition, vital signs, and mental status].

Accompanying Documentation:

The following documents are attached to this transfer packet:

- Current Medication Administration Record (MAR)
- Most Recent Physician History and Physical (H&P)
- Advanced Directives / DNR Status
- Tuberculosis (TB) Screening Results
- Functional Assessment (ADL Status)
- Insurance and Identification Copies

Personal Belongings:

[List items sent with resident, e.g., Clothing, hearing aids, dentures, eyeglasses, or medications].

Contact Information:

Primary Care Physician: [Doctor Name] - [Phone Number]

Responsible Party/Next of Kin: [Family Member Name] - [Phone Number]

If you have any questions regarding this transfer or require additional clinical information, please contact our nursing department at [Your Facility Phone Number].

Sincerely,

[Signature]

[Printed Name]

[Title/Position]

[Current Facility Name]