

**Date:** [Date]

**RE:** [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

**To:** Admissions Coordinator / Nursing Staff

**Receiving Facility:** [Name of Receiving Facility]

### **1. Transfer Overview**

The patient is being transferred from [Sending Facility Name] for long-term care and management of progressive cognitive decline. The patient is medically stable for transport via [Ambulance/Wheelchair Van].

### **2. Primary Diagnosis**

[Type of Dementia, e.g., Alzheimer's, Vascular, or Unspecified Dementia] with associated cognitive decline.

### **3. Cognitive and Behavioral Status**

- **Baseline Mentation:** [e.g., Alert but disoriented to time and place]
- **Communication:** [e.g., Verbal but repetitive / Non-verbal]
- **Behavioral Concerns:** [e.g., Wandering, sun-downing, or agitation]
- **Safety:** [e.g., High fall risk / Requires bed alarms]

### **4. Functional Status (ADLs)**

- **Ambulation:** [e.g., Independent with walker / Assist of 1]
- **Feeding:** [e.g., Self / Setup required / Texture modified diet]
- **Toileting:** [e.g., Incontinent / Scheduled toileting]

### **5. Medical History & Medications**

- **Comorbidities:** [e.g., Hypertension, Diabetes, Depression]
- **Medication Changes:** [List any recent changes to psychotropic or sedative meds]
- **Allergies:** [List Allergies]

### **6. Legal and Advance Directives**

- **Code Status:** [DNR / DNI / Full Code]
- **Power of Attorney (POA):** [Name and Contact Number]

### **7. Attachments Included**

- Current Medication Administration Record (MAR)
- Recent Lab Results and Imaging
- Physical/Occupational Therapy Notes
- Signed Transfer Orders

Please contact [Physician Name] at [Phone Number] for any clinical clarifications.

Sincerely,

[Signature]

[Printed Name and Title]

[Sending Facility Name]