

**Date:** [Date]

**RE: Patient Transfer Discharge Summary**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Date of Admission:** [Admission Date]

**Date of Discharge:** [Discharge Date]

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

**From:** [Surgical Department/Hospital Name]

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## 1. Surgical Summary

**Procedure Performed:** [Type of Surgery]

**Date of Surgery:** [Surgery Date]

**Surgeon:** [Surgeon Name]

**Post-Operative Course:** [Briefly describe recovery and any complications].

## 2. Current Clinical Status

**Vital Signs:** [BP, HR, Temp, O2 Sat]

**Mental Status:** [Alertness level, orientation, baseline cognitive status]

**Mobility:** [Weight-bearing status, assistance required, equipment needed]

## 3. Wound Care and Nursing Requirements

**Incision Site:** [Location, appearance, dressing type]

**Suture/Staple Removal:** [Scheduled date or "N/A"]

**Drains/Tubes:** [Description of any active drains or catheters]

## 4. Medication Orders

Please refer to the attached Medication Administration Record (MAR). Notable changes include:

**New Medications:** [List]

**Discontinued Medications:** [List]

## 5. Rehabilitation and Therapy Plan

- **Physical Therapy:** [Frequency and goals]
- **Occupational Therapy:** [Frequency and goals]
- **Special Precautions:** [Fall risk, aspiration risk, etc.]

## **6. Follow-up Appointments**

**Surgical Follow-up:** [Date, Time, Location]

**Other Consults:** [List any other scheduled specialists]

**Contact Information:**

For urgent clinical questions regarding this transfer, please contact [Contact Name/Role] at [Phone Number].

Sincerely,

[Signature]

[Printed Name and Title]

[Department]