

DISCHARGE AND TRANSFER SUMMARY

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

Receiving Facility: [Specialized Hospital Name]

Receiving Physician/Surgeon: [Surgeon Name/Department]

1. ADMISSION OVERVIEW

Date of Admission: [Date]

Reason for Admission: [Initial Diagnosis/Symptoms]

2. CLINICAL COURSE

[Briefly describe treatment provided, diagnostic tests performed, and current stability of the patient.]

3. REASON FOR TRANSFER

Patient requires specialized surgical intervention for [Specific Condition] which is not available at this facility. Specifically: [List Required Procedure/Specialty Care].

4. CURRENT MEDICATIONS

[List name, dosage, and frequency]

5. VITAL SIGNS AT TIME OF TRANSFER

BP: [BP]

HR: [Heart Rate]

Temp: [Temperature]

O2 Sat: [Oxygen Saturation]

6. ATTACHMENTS PROVIDED

- Imaging Reports (CT/MRI/X-ray)
- Laboratory Results
- Previous Operative Notes (if applicable)

7. CONTACT INFORMATION

Referring Physician: [Name]
Contact Number: [Phone Number]

Signature