

[Date]

[Receiving Physician Name]

[Receiving Practice Name]

[Address]

[City, State, Zip Code]

**RE: Transfer of Care for [Patient Full Name]**

Dear Dr. [Last Name],

The purpose of this letter is to formally transfer the medical care of [Patient Name], Date of Birth [DOB], from my pediatric practice to your adult primary care practice effective [Date].

**Medical Summary:**

- **Primary Diagnoses:** [List chronic conditions]
- **Surgical History:** [List major surgeries]
- **Allergies:** [List allergies and reactions]
- **Current Medications:** [List medication, dosage, and frequency]

**Immunization Status:**

The patient is up to date on all age-appropriate vaccinations. A full immunization record is attached to this letter.

**Transition Readiness:**

[Patient Name] has been prepared for the transition to adult care. They are aware of their medical history and are capable of [managing medications/scheduling appointments/understanding their insurance].

**Special Considerations:**

[Note any ongoing specialist referrals, psychosocial needs, or specific follow-up items required].

Complete medical records are enclosed for your review. If you have any questions regarding this patient's history, please do not hesitate to contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Pediatric Practice Name]

Enclosures: [Medical Records, Immunization Record, Recent Lab Results]