Date: [Date]

RE: Transfer of Care for [Patient Full Name]
Date of Birth: [DOB]
Relocation Date: [Date of Move]

To: [Receiving Physician Name or Facility Name]
Address: [New Address in Destination State]
Phone/Fax: [New Contact Information]

Dear Dr. [Physician Last Name],

The purpose of this letter is to formally transfer the medical care of [Patient Name], who is relocating from [Current State] to [New State] to be closer to [Family/Support System]. I have managed this patient's care since [Year].

Current Problem List & Diagnoses:

- [Diagnosis 1, e.g., Hypertension]
- [Diagnosis 2, e.g., Type 2 Diabetes]
- [Diagnosis 3, e.g., Mild Cognitive Impairment]
- [Diagnosis 4, e.g., Osteoarthritis]

Active Medications:

- [Medication Name], [Dosage], [Frequency]
- [Medication Name], [Dosage], [Frequency]

Cognitive and Functional Status:
[Note baseline mental status, MMSE/MoCA scores, and ADL/IADL assistance requirements.]

Social Situation:
The patient will be residing at [Private Residence / Assisted Living Facility]. Primary caregiver contact is [Name] at [Phone Number].

Recent Labs and Diagnostic Tests:
[Note significant recent findings or attach reports.]

Pending Issues/Recommendations:
[Note upcoming screenings, specialist referrals, or medication titrations needed.]

I have provided the patient with a 30-day supply of all maintenance medications to ensure continuity during this transition. Attached please find the most recent clinical summaries and immunization records.

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Your Name, MD/DO/NP/PA]
[Practice Name]
[Contact Information]