[Current Date]

[Receiving Physician Name]
[Receiving Practice Name]
[Street Address]
[City, State, Zip Code]

RE: Transfer of Orthopedic Care
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Date of Surgery (if applicable): [MM/DD/YYYY]

Dear Dr. [Receiving Physician Last Name],

The purpose of this letter is to formally transfer the orthopedic care of [Patient Name] to your practice, as the patient is relocating to your area on [Relocation Date].

Diagnosis:
[Insert Primary Diagnosis, e.g., Left Total Knee Arthroplasty / Lumbar Stenosis]

Clinical Summary:
The patient was under my care for [Duration of Treatment]. Their most recent clinical status is [Stable / Improving / Requiring Follow-up]. [Briefly describe recent surgical intervention or conservative management].

Current Treatment Plan & Recommendations:
[Insert specific instructions, e.g., Weight-bearing status, Physical Therapy frequency, or upcoming hardware removal].

Medications:
[List relevant medications or state "See attached medication list"]

Attached to this letter, please find the following documentation:
- Recent operative reports
- Progress notes from the last three visits
- Recent imaging reports (X-ray, MRI, CT)
- Physical Therapy discharge summary or current status

Thank you for assuming the orthopedic management of this patient. Please contact my office at [Phone Number] or [Email Address] if you require further clarification.

Sincerely,

[Physician Signature]
[Physician Printed Name]

[Current Practice Name]
[NPI Number]