

Date: [Date]

RE: Transfer of Obstetric Care

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Estimated Due Date (EDD): [EDD]

To [New Physician Name/Clinic Name],

This letter is to formally transfer the obstetric care of [Patient Name] to your practice, effective [Date], due to the patient's relocation to [New City/State].

Pregnancy Summary:

- **Current Gestational Age:** [Number] weeks
- **Gravity/Parity:** G[#] P[#]
- **Blood Type/Rh:** [Type]
- **Significant Medical History:** [List conditions or 'None']
- **Pregnancy Complications:** [List complications or 'None']
- **Current Medications:** [List medications]

Recent Test Results:

- **Genetic Screening:** [Results/Not performed]
- **Glucose Challenge Test:** [Results/Pending]
- **GBS Status:** [Results/Pending]
- **Ultrasound Findings:** [Summary of latest scan]

The patient's complete prenatal records, including lab reports and imaging, are attached to this correspondence. Her last prenatal visit was on [Date].

Please contact our office at [Your Phone Number] if you require any further information regarding this patient's care.

Sincerely,

[Provider Signature]

[Provider Printed Name]

[Clinic Name]

[Clinic Address]