

Date: [Date]

To: [Obstetrician Name]

Clinic Name: [OBGYN Practice Name]

Address: [OBGYN Address]

RE: Transfer of Obstetric Care

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

EDD: [Estimated Due Date]

Dear Dr. [Obstetrician Last Name],

We are pleased to transition the care of [Patient Name] to your practice for continued prenatal management and delivery. The patient achieved pregnancy via [Type of Treatment: e.g., IVF, ICSI, IUI, or Natural Cycle].

Pregnancy Details:

- **LMP:** [Last Menstrual Period]
- **Conception/Transfer Date:** [Date]
- **Current Gestational Age:** [Weeks/Days]
- **Number of Fetuses:** [Single/Twins]

Ultrasound Findings:

[Details of most recent scan, including heart rate and crown-rump length].

Medications and Support:

The patient is currently prescribed: [List medications, e.g., Progesterone, Estrogen, Prenatal Vitamins].

We have advised the patient to continue this regimen until [Date/Gestational Week].

Relevant Medical History:

[Note any relevant history: e.g., OHSS, prior losses, genetic screening results, or pre-existing conditions].

Full medical records and lab results are enclosed with this letter. Please do not hesitate to contact our office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name]
[Fertility Clinic Name]