Date: [Date]

Re: [Patient Name]
Date of Birth: [Patient Date of Birth]
Patient ID/MRN: [Patient Medical Record Number]

From: [Pediatric/Adolescent Provider Name], [Department Name]

To: [Adult Gynecologist Name/Facility Name]

Dear Dr. [Provider Last Name],

The purpose of this letter is to formally transfer the gynecological care of [Patient Name] to your practice as they transition into adult medicine.

Clinical Summary:
[Patient Name] has been seen in our clinic since [Start Date]. Their primary diagnoses and reasons for consultation include:

- [Diagnosis 1]
- [Diagnosis 2]

Menstrual History:
Age of Menarche: [Age]
Cycle Frequency/Regularity: [Description]
Last Menstrual Period: [Date]

Relevant Medical & Surgical History:
[Include history of surgeries, chronic conditions, or pelvic imaging results]

Current Medications & Contraception:
[List medications, dosages, and current birth control method if applicable]

Screening History:
Cervical Cancer Screening (Pap Smear): [Date/Result or N/A]
HPV Vaccination Status: [Complete/Incomplete/Dates]
STI Screening: [Recent results if applicable]

Social & Sexual History:
[Relevant information regarding sexual activity, gender identity, and support systems]

Provider Recommendations:
We recommend the following follow-up care for this patient: [e.g., Annual exam, specific medication titration, or repeat imaging].

Attached are the most recent laboratory results, imaging reports, and clinic notes. Please contact our office at [Phone Number] if you require further information.

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]