Date: [Date]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]

To: [Receiving Physician/Practice Name]

Address: [Practice Address]

Dear Dr. [Physician Last Name],

The purpose of this letter is to formally transfer the medical care of [Patient Name] from [Current Practice Name] to your practice, effective [Effective Date]. This transfer is occurring due to [Reason for Transfer: e.g., patient relocation, insurance change, or specialized care requirements].

Clinical Summary:

- **Primary Diagnoses:** [List chronic conditions, e.g., Hypertension, Type 2 Diabetes]
- **Current Medications:** [List medications or refer to attached list]
- **Allergies:** [List allergies]
- **Recent Procedures/Labs:** [Briefly mention recent relevant tests]

Attached to this letter, please find the patient's comprehensive medical records, including recent laboratory results, imaging reports, and vaccination records. Our team has advised the patient to contact your office to schedule an initial consultation.

We remain available for any questions regarding this patient's medical history during this transition period. Please contact our office at [Your Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Current Practice Name]
[Contact Information]

Enclosures: [List attached documents, e.g., Lab results, Medication list, Summary of care]