Date: [Date]

RE: Transfer of Care - Post-Operative Rehabilitation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Hospital ID: [ID Number]
Date of Surgery: [Date]

To: [Receiving Clinician/Facility Name]

Clinical Summary:
The patient is being transferred to your facility following a craniotomy for [Indication, e.g., tumor resection, hematoma evacuation, aneurysm repair]. The procedure was performed on [Date] by Dr. [Surgeon Name]. The intraoperative course was [uneventful/noted for complications].

Post-Operative Status:
Since surgery, the patient has been monitored in the [ICU/Neurological Ward]. Current neurological status is [Stable/Improving]. Most recent GCS score is [Score]. Motor function is [Describe, e.g., 5/5 in all extremities or specific deficits]. Speech is [Fluent/Aphasic/Dysarthric].

Current Medications:
- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]
- [Note: Steroid tapering schedule if applicable]
- [Note: Anti-epileptic drug regimen if applicable]

Wound Care & Precautions:
- Incision Site: [Location, e.g., Right Frontal]
- Closure Type: [Sutures/Staples/Glue]
- Removal Date: [Planned Date]
- Activity Restrictions: [e.g., No lifting > 5lbs, Head of bed > 30 degrees]
- Seizure Precautions: [Yes/No]

Rehabilitation Goals:
The primary goals for this transfer include [Physical Therapy/Occupational Therapy/Speech Therapy] to address [Specific Deficits]. We request monitoring for post-operative complications including CSF leak, infection, or changes in mental status.

Follow-Up:
The patient is scheduled for a follow-up appointment with Neurosurgery on [Date] at [Time].

Please contact [Name/Department] at [Phone Number] for any urgent clinical inquiries during this transition.

Sincerely,

[Doctor Name/Signature]
[Title/Department]
[Hospital Name]