Date: [Date]

To: Admissions Department / Nursing Director
Facility Name: [SNF Name]
Facility Address: [SNF Address]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

Dear Clinical Staff,

Please accept this letter and the attached documentation for the formal transfer of medical care for the above-named patient from [Clinic Name] to [SNF Name].

Reason for Transfer:
[Insert reason: e.g., Post-acute rehabilitation, long-term care placement, wound management]

Primary Diagnoses:
1. [Diagnosis 1]
2. [Diagnosis 2]
3. [Diagnosis 3]

Clinical Summary:
[Insert brief medical history and current clinical status]

Key Care Requirements:
- Diet: [e.g., Regular, Pureed, Low Sodium]
- Mobility: [e.g., Non-weight bearing, Assist of 1, Bedbound]
- Specialized Care: [e.g., Oxygen, Wound Vac, IV Antibiotics]

Attachments Included:
- Current Medication List (MAR)
- Problem List and Surgical History
- Most Recent Lab Results and Imaging
- Immunization Record
- Advanced Directives / POLST

The patient's primary care physician at our clinic, [Physician Name], is available for any clarifying questions during this transition. Please contact our office at [Phone Number] for further information.

Sincerely,

[Signature]
[Printed Name and Title]
[Clinic Name]