Date: [Date]

To: Admissions Department / Nursing Staff
Facility Name: [SNF Name]
Facility Fax/Phone: [Facility Phone/Fax]

RE: Patient Transfer

- **Patient Name:** [Patient Full Name]
- **Date of Birth:** [DOB]
- **Date of Surgery:** [Surgery Date]
- **Procedure:** [Specific Surgical Procedure]
- **Surgeon:** [Surgeon Name]

Dear Nursing and Rehabilitation Staff,

The above-named patient is being discharged from [Hospital/Clinic Name] to your facility for post-operative sub-acute rehabilitation and skilled nursing care.

Clinical Summary:
The patient underwent an uncomplicated [Procedure Name]. Post-operative imaging shows [Stable Hardware/Proper Alignment]. The patient is medically stable for transfer.

Weight Bearing Status:
[e.g., Non-Weight Bearing / Partial Weight Bearing / Weight Bearing as Tolerated] on the [Left/Right] [Body Part].

Wound Care:
[e.g., Keep dressing clean and dry. Do not remove surgical staples until follow-up appointment.]

Medications:
Please refer to the attached medication reconciliation sheet for pain management, DVT prophylaxis (anticoagulation), and routine medications.

Physical Therapy:
Initiate PT/OT evaluation and treatment daily. Focus on [e.g., Range of motion, gait training, ADLs].

Follow-Up:
The patient is scheduled to see Dr. [Surgeon Name] on [Date] at [Time] at our [Location] office.

If there are any acute concerns regarding the surgical site or orthopedic status, please contact our office at [Office Phone Number].

Sincerely,

[Doctor Name/Signature]
[Clinic Name]
[Contact Information]