Date: [Insert Date]

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

RE: Patient Transfer
Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
MRN: [Insert MRN]

Dear Admissions Team,

This letter serves as a formal transfer summary for the above-named patient transitioning from [Clinic Name] to your Skilled Nursing Facility for [Short-term Rehab / Long-term Care].

1. Primary Diagnoses:
[List primary conditions, e.g., Chronic Heart Failure, Dementia, Recent Hip Fracture]

2. Reason for Transfer:
[Reason, e.g., Post-acute stabilization, physical therapy requirements, or inability to perform ADLs at home]

3. Current Medications:
[See attached medication administration record / List key medications here]

4. Functional Status & Assistive Devices:
[e.g., Weight-bearing status, use of walker/wheelchair, assistance needed for toileting/feeding]

5. Mental Status & Code Status:
[e.g., Alert and oriented x3, or Cognitive impairment level]
Code Status: [DNR / Full Code / DNI]

6. Recent Labs & Procedures:
[Attached: Most recent labs, imaging, and COVID-19/TB clearance status]

7. Contact Information:
For clinical questions, please contact [Provider Name] at [Phone Number].
Family/Next of Kin: [Name] at [Phone Number].

Thank you for accepting this patient into your care.

Sincerely,

[Physician/Provider Signature]
[Physician/Provider Printed Name]

[Clinic Name]
[Phone/Fax]