Date: [Date]

RE: [Patient Full Name]
Date of Birth: [DOB]
Date of Admission: [Admission Date]
Date of Transfer: [Transfer Date]

To: Admissions Department / Nursing Director
Facility Name: [Receiving Skilled Nursing Facility Name]

1. CLINICAL DIAGNOSIS
The patient is being transferred following an acute [Ischemic / Hemorrhagic] Stroke affecting the [Left / Right / Bilateral] [Specific Brain Region].

2. NEUROLOGICAL STATUS & DEFICITS
At the time of discharge, the patient exhibits the following:
- **Motor:** [e.g., Right-sided hemiplegia, weakness]
- **Communication:** [e.g., Aphasia, dysarthria, or intact]
- **Cognition:** [e.g., Alert, oriented x3, or cognitive impairments]
- **Swallowing:** [e.g., Dysphagia - Requires thickened liquids / NPO / Regular]

3. CURRENT MEDICATIONS
Please refer to the attached Medication Administration Record (MAR). Key stroke-prevention medications include:
- Antiplatelets/Anticoagulants: [Medication Name and Dosage]
- Statins: [Medication Name and Dosage]
- Antihypertensives: [Medication Name and Dosage]

4. REHABILITATION GOALS
The primary goal of this transfer is continued recovery through intensive therapy. Please provide:
- Physical Therapy (PT) for mobility and gait training.
- Occupational Therapy (OT) for activities of daily living (ADL) retraining.
- Speech Therapy (ST) for swallow safety and communication.

5. FOLLOW-UP CARE
The patient is scheduled for a follow-up neurology appointment on [Date/Time] at [Clinic Location].

6. CONTACT INFORMATION
For clinical questions regarding this transfer, please contact [Physician Name] at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Neurology Clinic Name]