Date: [Date]

TO: Admissions Department / Nursing Director
Facility Name: [SNF Name]
Phone/Fax: [SNF Contact Info]

RE: Transfer of Care / Palliative Consultation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Diagnosis: [Primary Oncology Diagnosis]

Clinical Summary:

[Patient Name] is being transferred to your facility for skilled nursing care. The patient has a diagnosis of [Stage/Type of Cancer] and is currently under the care of [Oncologist Name] at [Clinic Name]. The goal of care is currently focused on **Palliative Support** and symptom management.

Current Treatment Status:

- Active Treatment: [Yes/No - e.g., Chemotherapy/Radiation]
- Last Treatment Date: [Date]
- Next Scheduled Follow-up: [Date/Time]

Symptom Management & Palliative Needs:

- **Pain Management:** [Current Regimen/Dosage]
- **Nausea/Emesis:** [Current Regimen]
- **Respiratory:** [Oxygen Needs/Dyspnea Management]
- **Wound Care:** [Specific Instructions if applicable]

Code Status: [DNR/DNI/Full Code]

Special Instructions:

[Include instructions for lab draws, hydration, or specific oncology-related precautions].

Contact Information:

For oncology-related clinical concerns, please contact our clinic at [Phone Number].
After-hours on-call physician: [Phone Number].

Sincerely,

[Signature]
[Provider Name, Title]
[Clinic Name]