Date: [Date]

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

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

Dear Admissions Team,

This letter serves as a formal transfer of care for the above-named patient from [Clinic Name] to your Skilled Nursing Facility for continued rehabilitation services.

Primary Diagnosis: [Primary Diagnosis necessitating rehab]

Secondary Diagnoses: [List relevant comorbidities]

Current Clinical Status:
The patient is currently medically stable but requires a supervised setting for intensive physical and occupational therapy. Recent evaluations indicate [briefly mention functional deficits, e.g., gait instability, inability to perform ADLs].

Treatment Goals:
The primary goal of this transfer is to provide the patient with [list goals, e.g., 24-hour nursing care, daily physical therapy, wound management] to facilitate a safe transition back to their primary residence.

Enclosed Documentation:
- Recent History and Physical (H&P)
- Current Medication Administration Record (MAR)
- Physical/Occupational Therapy progress notes
- Most recent laboratory and imaging results
- Insurance authorization forms

The patient is scheduled to arrive at your facility on [Date] at [Time] via [Mode of Transport].

Please contact our office at [Phone Number] or via email at [Email Address] if you require additional information regarding this transition.

Sincerely,

[Physician/Provider Name]
[Title]
[Clinic Name]