Date: [Date]

To: Admitting Physician / Nursing Director
Facility Name: [SNF Name]
Address: [SNF Address]

RE: Patient Transfer and Endocrinology Management Plan

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Transfer: [Date]

1. Primary Endocrine Diagnoses:

- [e.g., Type 2 Diabetes Mellitus]
- [e.g., Hypothyroidism]
- [e.g., Adrenal Insufficiency]

2. Glucose Management Protocol:

Fingerstick Monitoring (FSBS): [e.g., AC and HS / Q6 Hours]
Target Glucose Range: [e.g., 100-180 mg/dL]

Current Insulin/Medication Orders:

- **Basal:** [Dose/Frequency]
- **Prandial (Bolus):** [Dose/Frequency]
- **Correctional (Sliding Scale):** [Attached/Specify]
- **Oral Agents:** [Medication/Dose/Frequency]

3. Hypoglycemia Protocol:

If FSBS is less than [70 mg/dL], initiate standard hypoglycemia protocol (15g rapid-acting carbs). Notify provider if patient is unresponsive or if blood sugar remains low after two treatments.

4. Other Endocrine Medications:

- [Medication Name]: [Dose] [Frequency]
- [Medication Name]: [Dose] [Frequency]

5. Special Instructions:

[e.g., Wound care for diabetic foot ulcers, continuous glucose monitor (CGM) sensor changes, or adrenal crisis emergency instructions.]

6. Follow-up Care:

The patient has a follow-up appointment at our clinic on: [Date/Time].

Contact Information:

For urgent endocrine concerns, please contact [Provider Name] at [Phone Number].

Sincerely,

[Physician Signature]
[Printed Name and Credentials]
[Clinic Name]