Date: [Date]

From:
[Referring Provider Name]
[Clinic/Facility Name]
[Contact Information]

To:
[Receiving Provider Name]
[Clinic/Facility Name]
[Contact Information]

RE: Hypertension Continuity of Care Transfer

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Dear [Receiving Provider Name],

This letter is to formally transfer the primary management of hypertension for the above-named patient to your care. The patient has been informed of this transition and is in agreement.

Clinical Summary:

- **Diagnosis:** [e.g., Essential Hypertension / Secondary Hypertension]
- **Diagnosis Date:** [Date]
- **Current Blood Pressure:** [BP Reading] mmHg (as of [Date])
- **Target Blood Pressure:** [Target BP, e.g.,

Current Medication Regimen:

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

Relevant Medical History & Labs:

- **Comorbidities:** [e.g., Diabetes, CKD, Hyperlipidemia]
- **Latest Creatinine/eGFR:** [Value] ([Date])
- **Latest Potassium:** [Value] ([Date])
- **Known Allergies:** [List Allergies]

Last Treatment Note:
[Brief summary of recent adjustments or lifestyle recommendations]

Please find the attached clinical records and laboratory results for more detailed information. If you require further clarification, please do not hesitate to contact my office.

Sincerely,

[Signature]
[Printed Name]
[Credentials]