Date: [Date]

To: [Receiving Provider/Clinic Name]
Attention: [Provider Name]
Address: [Clinic Address]

RE: Transfer of Care

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Admission: [Admission Date]
Date of Discharge: [Discharge Date]

Dear [Provider Name],

This letter serves to formally transfer the psychiatric care of the above-named patient from [Inpatient Facility Name] to your outpatient services. The patient has been stabilized and is deemed appropriate for community-based treatment.

Discharge Diagnosis:
[Primary Diagnosis and ICD-10 Code]
[Secondary Diagnoses]

Clinical Summary:
[Brief summary of reason for admission, hospital course, and response to treatment.]

Risk Assessment at Discharge:
[Details regarding suicide/self-harm risk, ideation, and safety plan status.]

Current Medication Regimen:
[List of medications, dosages, and frequencies]

Recommended Follow-up Plan:
[Specific frequency of therapy or medication management sessions required.]

Please find the attached Discharge Summary, Medication List, and Safety Plan for your records. If you require further clinical information, please contact our department at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name and Title]
[Inpatient Facility Name]
[Contact Information]