Date: [Date]

RE: Transfer of Care for [Patient Full Name]
DOB: [Date of Birth]
ID Number: [Patient ID/Chart Number]

To: [Receiving Facility/Provider Name]
Attention: [Admissions Department/Specific Clinician]

From: [Sending Clinician Name/Title]
Facility: [Sending Facility Name]
Phone: [Phone Number]

1. Transfer Reason
The above-named patient is being transferred for: [Higher level of care/Step-down/Specialized dual diagnosis treatment].

2. Psychiatric Diagnosis (ICD-10)
[List primary and secondary mental health diagnoses]

3. Substance Use Diagnosis (ICD-10)
[List primary and secondary substance use disorders, including severity]

4. Current Clinical Status
Psychiatric Symptoms: [Brief description of current mood, psychosis, or anxiety levels]
Withdrawal Status: [Last dose of substances, current CIWA/COWS scores, or detoxification stage]
Risk Assessment: [Current status of Suicidal/Homicidal ideation or self-harm]

5. Current Medications
[List medication name, dosage, frequency, and last administered time]

6. Recent Labs and Vitals
Toxicology Screen: [Results/Date]
Vital Signs: [BP, HR, Temp, RR]
Notable Labs: [BAL, Liver Enzymes, CBC, etc.]

7. Treatment Summary
[Brief summary of interventions provided, patient's response to treatment, and specific behavioral triggers].

8. Discharge/Transfer Disposition
Transportation: [Ambulance/Private Vehicle/Facility Transport]
Legal Status: [Voluntary/Involuntary/Guardianship status]

Sincerely,

[Signature]
[Printed Name and Credentials]
[Contact Information]