Date: [Date]

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

To: [Receiving Facility/Provider Name]
From: [Sending Physician/Facility Name]

Reason for Transfer:
[Briefly state reason, e.g., transition to long-term memory care, stabilization of acute psychosis, or discharge to skilled nursing].

Psychiatric Diagnoses:
1. [Diagnosis, e.g., Major Neurocognitive Disorder due to Alzheimer's]
2. [Diagnosis, e.g., Late-life Depression with Psychotic Features]
3. [Diagnosis]

Current Psychiatric Medications:
[Medication Name, Dosage, Frequency, and Indication]

Medical Comorbidities:
[List relevant chronic conditions, e.g., Hypertension, Diabetes, Fall Risk]

Summary of Hospital Course:
[Brief summary of behavioral interventions, medication adjustments, and current mental status].

Behavioral Status & Safety:
Aggression: [Yes/No/Describe]
Wandering: [Yes/No]
Self-Harm Risk: [Low/Medium/High]
Legal Status: [Voluntary/Involuntary/Guardianship status]

Functional Status:
ADLs: [Independent/Requires Assistance]
Mobility: [Ambulatory/Walker/Wheelchair]

Follow-up Recommendations:
[Required labs, upcoming appointments, or monitoring instructions]

Contact Information:
For questions regarding this transfer, please contact [Name/Department] at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Facility Name]