Date: [Date]

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

To: [Receiving Provider/Clinic Name]
Address: [Clinic Address]
Phone: [Clinic Phone Number]

Dear [Provider Name or Intake Coordinator],

The purpose of this letter is to formally transfer the psychiatric care of [Patient Name] from my telepsychiatry practice to your in-person clinical setting, effective [Transfer Date].

Reason for Transfer:
The patient requires in-person clinical assessment and management due to [Reason: e.g., clinical complexity, need for physical vitals monitoring, patient preference, or acuity level].

Clinical Summary:
[Patient Name] has been under my care via telehealth since [Start Date]. The current primary diagnosis is [Diagnosis/ICD-10 Code]. Our recent focus has been on [Brief Treatment Focus].

Current Medications:

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

I have provided the patient with a final [30/60/90]-day supply of medications to ensure continuity of care during this transition.

Safety Assessment:
At the time of last evaluation on [Date], the patient was [Stable/Risk Level]. There is [No / A] history of [Recent Hospitalizations/Self-Harm].

Please find the attached clinical notes and most recent lab results for your review. I will remain available for consultation until your initial intake appointment on [Date, if scheduled].

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Credentials/Title]

[Your Practice Name]
[Your Phone/Email]