

Date: [Date]

To: [Receiving Physician Name]

Facility: [Receiving Facility Name]

Department: [Department Name]

RE: Patient Transfer of Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

Dear [Physician Name],

This letter is to formally transfer the post-operative care of the above-named patient following surgical intervention for [Type of Cancer/Diagnosis].

Surgical Summary:

- **Date of Surgery:** [Date]
- **Procedure:** [Detailed Name of Procedure]
- **Surgeon:** [Surgeon Name]
- **Findings:** [Brief Description of Intraoperative Findings/Tumor Size]
- **Pathology (Preliminary/Final):** [Pathology Results]
- **Margins:** [Clear/Involved/Close]

Post-Operative Course:

[Describe hospital stay, any complications, and current clinical status.]

Active Medications:

[List medications, including pain management and anticoagulation.]

Wound and Device Care:

- **Incision Status:** [Sutures/Staples/Dressing type]
- **Drains/Tubes:** [Type, location, and output requirements]
- **Activity Restrictions:** [Lifting limits, mobility status]

Follow-Up Plan:

- **Surgical Follow-up:** [Date and Time]
- **Oncology (Medical/Radiation):** [Referral Details]
- **Imaging/Labs:** [Scheduled tests]

Please contact my office at [Phone Number] or via email at [Email Address] if you have any questions regarding this patient's recovery plan.

Sincerely,

[Signature]

[Printed Name and Title]

[Organization/Hospital Name]