Date: [Date]

To: [Receiving Facility/Physician Name]
Department: [Oncology/Infusion Department]
Address: [Facility Address]

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

Dear Transfer Coordinator,

This letter serves to formally transfer the oncological care and infusion services for the above-named patient from [Sending Facility Name] to your center, effective [Transfer Date].

Diagnosis: [Primary Diagnosis and ICD-10 Code]

Current Treatment Plan:
Regimen: [Name of Chemotherapy Regimen]
Cycle Number: [Cycle #] of [Total Cycles]
Last Dose Administered: [Date of Last Infusion]
Next Dose Due: [Scheduled Date of Next Infusion]

Clinical Summary:
[Brief summary of patient response to treatment, recent lab results, and any adverse reactions or complications.]

Required Documentation Attached:

- Current Pathology and Imaging Reports
- Most Recent Clinical Progress Notes
- Complete Medication List and Allergy Profile
- Flowsheets of Previous Infusions
- Recent CBC and Metabolic Panels

Referring Physician Contact:
Name: [Physician Name]
Phone: [Phone Number]
Email: [Email Address]

Please contact our office to confirm receipt of these records and to finalize the transition of care.

Sincerely,

[Signature]
[Printed Name and Title]
[Sending Facility Name]