Date: [Date]

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

To: [Receiving Provider Name/Clinic]
From: [Sending Provider Name/Clinic]
Specialty: [Specialty Name]

Dear [Recipient Name],

The purpose of this letter is to formally transfer the specialty care of [Patient Name] to your practice, effective [Date].

Reason for Transfer:
[Reason: e.g., Relocation, Transition from Pediatric to Adult Care, Change in Insurance]

Current Diagnosis and Clinical Summary:
[Insert brief summary of diagnosis and current health status]

Active Medications:
[List current medications and dosages]

Past Procedures and Results:
[List relevant surgeries or recent test results]

Pending Follow-ups:
[Detail any outstanding labs or upcoming appointments]

All relevant medical records, including imaging and laboratory reports, are attached to this letter. Our office will provide a final prescription refill for [Number] days to ensure continuity of care during this transition.

If you require further information regarding this patient's history or treatment plan, please contact our office at [Phone Number] or via email at [Email Address].

Sincerely,

[Provider Signature]
[Provider Printed Name]
[Clinic/Institution Name]