Date: [Insert Date]

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

To: [Receiving Clinician/Facility Name]
Department: [Department Name]
Address: [Address Line 1, City, State, Zip]

From: [Your Name/Current Case Manager]
Organization: [Current Facility Name]
Contact Information: [Phone/Email]

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1. Reason for Transfer

[Briefly describe why the patient is being transferred, e.g., transition to long-term care, escalation of specialist services, or geographical relocation.]

2. Clinical Summary and Diagnosis

Primary Diagnosis: [Enter Primary Condition]
Secondary Diagnoses/Comorbidities: [List relevant chronic conditions]
Current Clinical Status: [Stable/Guarded/Improving]

3. Medications and Treatments

Active Medications: [List or attach current MAR]
Pending Labs/Procedures: [List any outstanding tests or scheduled appointments]
Allergies: [List Allergies]

4. Complex Care Needs & Social Determinants

- **Mobility/ADLs:** [e.g., Requires assistance with bathing, uses walker]
- **Durable Medical Equipment (DME):** [e.g., Oxygen, CPAP, Hospital Bed]
- **Psychosocial Factors:** [e.g., Caregiver burden, cognitive impairment, transportation barriers]
- **Advanced Directives:** [Full Code/DNR/DNI/POLST on file]

5. Care Plan Goals

[Outline the short-term and long-term goals established with the patient/family.]

6. Transition Requirements

Follow-up Required: [List specific specialists and timeframe]
Home Health/Community Services: [List active agencies and contact info]

Please contact the undersigned for any clarifications regarding this patient's history or care requirements.

Sincerely,

[Signature]
[Printed Name and Credentials]
[Date]