Date: [Insert Date]

From: [Your Name/Lead Clinician]
[Your Department/Clinic Name]
[Contact Information]

To: [Receiving Provider Name]
[Receiving Department/Facility]
[Address]

RE: Transfer of Care / Transition Summary

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

1. Reason for Transfer
[State why the patient is being transferred, e.g., transition to primary care, relocation, or escalation of specialist services.]

2. Multidisciplinary Diagnosis & Clinical Summary
[Provide a brief history of the patient's condition and the primary diagnoses managed by the team.]

3. Current Treatment Team

- **Medical/Specialist:** [Name] - [Role]
- **Rehabilitation (PT/OT/SLP):** [Name] - [Role]
- **Mental Health/Social Work:** [Name] - [Role]
- **Nursing/Care Coordination:** [Name] - [Role]

4. Interventions & Progress to Date
[Summarize key treatments, surgeries, therapies, or medications administered and the patient's response.]

5. Current Medications
[List current dosages and frequencies or refer to an attached medication list.]

6. Ongoing Care Requirements & Recommendations
[Outline specific tasks for the receiving team, such as follow-up labs, pending tests, or therapy schedules.]

7. Goals of Care & Patient Preferences
[Note the patient's specific goals, advance directives, or psychosocial considerations.]

8. Attachments Included

- [ ] Latest Discharge Summary
- [ ] Most recent Lab Results/Imaging
- [ ] Medication List
- [ ] Therapy Progress Notes

Please contact our office at [Phone Number] if you require further clarification regarding this patient's care plan.

Sincerely,

[Signature]
[Printed Name and Credentials]
[Title/Role]