

**Date:** [Date]

**RE: Continuity of Care / Patient Transfer**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

Dear [Receiving Provider Name/Facility],

This letter is to provide clinical information for the above-named elderly patient who is being referred to your care for [Reason for Referral/Transfer].

**Primary Diagnoses:**

- [Diagnosis 1]
- [Diagnosis 2]
- [Diagnosis 3]

**Current Medications:**

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

**Allergies:** [List Allergies or NKA]

**Functional Status & Cognitive Assessment:**

[Note mobility aids, hearing/vision impairments, or recent MMSE/MoCA scores].

**Social Support:**

[Name of Health Care Proxy/Emergency Contact and Phone Number].

**Recent Clinical Findings:**

[Brief summary of recent lab results, vitals, or procedural findings].

**Follow-up Recommendations:**

[Specific actions needed from the receiving provider].

Please contact our clinic at [Phone Number] should you require additional medical records or clarification.

Sincerely,

[Provider Signature]

[Provider Name, Title]

[Clinic Name]