**Date:** [Date]

**RE: Medical Clearance and Transfer Order**

**Patient Name:** [Resident Full Name]
**Date of Birth:** [DOB]
**Transfer From:** [Sending Facility Name/Home]
**Transfer To:** [Assisted Living Facility Name]

---

To Whom It May Concern,

I have evaluated the above-named patient and reviewed their current medical status. I find the patient to be medically stable and appropriate for placement in an Assisted Living environment.

**Medical Clearance Confirmations:**

- The patient is free from communicable diseases in infectious stages (including negative TB screening).
- The patient does not require 24-hour skilled nursing intervention.
- The patient is mentally and physically capable of following emergency evacuation procedures with [minimal/moderate/total] assistance.

**Clinical Summary:**

**Primary Diagnoses:** [List Diagnoses]
**Allergies:** [List Allergies or NKA]
**Dietary Requirements:** [List Diet, e.g., Regular, Low Sodium]

**Transfer Orders:**

- Please admit patient to [Assisted Living Facility Name].
- Continue current medication regimen as per the attached Medication Administration Record (MAR).
- Level of Care Required: [e.g., Assistance with ADLs, Medication Management].
- Physical/Occupational Therapy: [None/Required].

Please find the attached History and Physical (H&P), current medication list, and immunization records for the patient's permanent file.

If you require further clinical information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
**Physician Name:** [Print Name]
**License Number:** [License #]
**Facility/Practice:** [Practice Name]