

**Date:** [Insert Date]

**To:** [Receiving Physician/Provider Name]

**Facility:** [Receiving Facility Name]

**Address:** [Facility Address]

**RE: Transfer of Care**

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

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

Dear [Recipient Name],

I am transferring the psychiatric care of the above-named patient to your service effective [Date]. The patient is being transferred for [Reason for Transfer: e.g., transition to long-term care, closer proximity to family, or change in level of care].

**Psychiatric Diagnoses:**

- [Primary Diagnosis, e.g., Major Depressive Disorder]
- [Cognitive Diagnosis, e.g., Alzheimer's Dementia with Behavioral Disturbance]
- [Other relevant diagnoses]

**Current Medications:**

[List psychotropic medications, dosages, and frequencies]

**Clinical Summary:**

[Brief description of cognitive status, mood stability, and recent behavioral issues. Include history of falls, wandering, or aggression if applicable.]

**Treatment Recommendations:**

[Detail any specific monitoring required, such as metabolic screening, EKG for QTc intervals, or behavior logs.]

**Advance Directives:**

**Code Status:** [Full Code / DNR]

**Healthcare Proxy/POA:** [Name and Contact Information]

Thank you for assuming the care of this patient. Please contact my office at [Phone Number] if you require further clinical details.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Credentials]

[Your Organization]