

**Date:** [Date]

**RE:** [Patient Full Name]

**Date of Birth:** [DOB]

**Date of Discharge from SNF:** [Discharge Date]

**To:** [Receiving Clinic Name / Primary Care Physician]

**Attn:** [Provider Name]

Dear [Provider Name],

This letter serves to formally transition the care of the above-named patient from [SNF Name] to your clinic following their completion of sub-acute rehabilitation.

**Reason for SNF Admission:**

[Brief description of clinical event, e.g., Post-op Hip Replacement, Stroke Recovery]

**Clinical Summary:**

During their stay, the patient received [Physical/Occupational/Speech] therapy. At the time of discharge, the patient is at their baseline functional status of [Describe: e.g., ambulatory with rolling walker]. Vital signs have remained stable, and all surgical sites are [Describe: e.g., healed/sutures removed].

**Current Medication List:**

[List medications or state: See attached Medication Reconciliation]

**Pending Labs/Tests:**

[List any outstanding results or state: None]

**Recommended Follow-Up Care:**

The patient has been instructed to follow up with your office within [Number] days. Please monitor the following specific concerns: [List concerns, e.g., blood pressure titration, wound check].

Attached you will find the complete Discharge Summary, Medication Reconciliation, and recent Physical Therapy notes.

If you have any questions regarding this transition, please contact our facility at [Phone Number].

Sincerely,

[Your Name/Signature]

[Your Title]

[SNF Name]