

**Date:** [Date]

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

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

**Address:** [Patient Address]

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

**From:** [Sending Clinician Name/Department]

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## 1. Reason for Transfer / Consultation

[Brief summary of why the patient is being transferred and the goals of care].

## 2. Medical History & Diagnoses

[List of chronic conditions, acute issues, and relevant surgical history].

## 3. Comprehensive Geriatric Assessment (CGA) Findings

- **Cognition:** [e.g., MMSE/MoCA scores, presence of dementia or delirium]
- **Mood:** [e.g., GDS score, signs of depression or anxiety]
- **Functional Status (ADLs/IADLs):** [Level of independence, use of mobility aids]
- **Fall Risk:** [Recent falls, gait/balance assessment results]
- **Nutrition:** [Weight trends, appetite, swallowing issues]
- **Continence:** [Bladder and bowel status]
- **Sensory:** [Vision or hearing impairments]

## 4. Medication Summary

[List of current medications, dosages, and any recent changes or adverse reactions].

## 5. Social and Environmental Factors

[Living arrangement, primary caregiver contact info, home safety concerns, and social support system].

## 6. Advance Care Planning

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

**Health Care Proxy:** [Name and Contact Number]

**Advance Directives:** [Attached / Not Attached]

## 7. Transfer Plan & Recommendations

[Follow-up appointments, pending lab results, and specific care instructions for the receiving team].

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**Signature:** \_\_\_\_\_

**Print Name/Title:** [Clinician Name]

**Contact Phone:** [Phone Number]