Date: [Date]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Relocation Date: [Move-in Date]

To: [Receiving Physician/Medical Director Name]
Facility Name: [Name of Assisted Living Facility]
Address: [Facility Address]

Dear Doctor,

This letter serves as a formal clinical handover for [Patient Name], who is relocating to your facility. I have served as the patient's primary care provider since [Year/Date].

Current Diagnoses:
[List primary chronic conditions, e.g., Hypertension, Type 2 Diabetes, Mild Cognitive Impairment]

Active Medications:
[List medication names, dosages, and frequency]

Allergies:
[List allergies or state "No Known Drug Allergies"]

Recent Clinical Summary:
[Briefly describe recent labs, cognitive status, or mobility concerns]

Immunization Status:
[Note last Flu, COVID-19, or Pneumonia vaccinations]

Advanced Directives:
[Specify: Full Code / DNR / DNI / Power of Attorney info]

Attached you will find the most recent encounter notes, laboratory results, and a signed medication administration record (MAR). Please contact my office at [Phone Number] if you require further clarification during this transition.

Sincerely,

[Signature]
[Physician Name, Credentials]
[Practice Name]
[Contact Information]