

Date: [Insert Date]

RE: Patient Transfer

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

To [Receiving Physician/Facility Name],

This letter is to formally transfer the care of [Patient Name] to your practice for continued chronic disease management. This patient is a [Age]-year-old individual with multiple comorbidities requiring ongoing geriatric supervision.

Primary Diagnoses:

- [Diagnosis 1, e.g., Type 2 Diabetes]
- [Diagnosis 2, e.g., Hypertension]
- [Diagnosis 3, e.g., Cognitive Impairment/Dementia]
- [Diagnosis 4, e.g., Osteoarthritis]

Current Medications:

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

Clinical Summary:

[Insert brief summary of recent stability, cognitive status, mobility levels, and recent lab results.]

Social History & Advance Care Planning:

- **Living Situation:** [e.g., Independent, Assisted Living, With Family]
- **Primary Caregiver:** [Name and Contact Info]
- **Code Status:** [e.g., Full Code / DNR / DNI]
- **Medical Proxy:** [Name and Contact Info]

Pending Follow-ups/Tests:

[List any outstanding appointments or pending diagnostic tests.]

The patient has been informed of this transfer. Please find the attached complete medical records for your review. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Facility/Practice Name]