Date: [Date of Transfer]

To: [Receiving Facility Name / Primary Care Physician Name]
From: [Sending Facility Name / Referring Physician Name]
Re: Emergency Medical Transfer for Primary Care Continuity

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]

1. Reason for Transfer:
[Brief description of the acute medical event and why the transfer is necessary for continued care.]

2. Clinical Summary:
[Summary of symptoms, diagnostic results, and interventions performed at this facility.]

3. Current Status:
Vital Signs: [BP, HR, RR, Temp, O2 Sat]
Mental Status: [Alert/Oriented/Other]
Stability: [Stable/Guarded/Critical]

4. Current Medications & Fluids:
[List all active medications, dosages, and IV fluids administered.]

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

6. Required Follow-Up / Plan of Care:
[Specific instructions for the receiving primary care team regarding monitoring or further testing.]

7. Contact Information:
For further clinical details, please contact [Physician Name] at [Phone Number].

Sincerely,

[Signature]
[Printed Name and Title]
[Facility Name]