

Date: [Date of Transfer]

To: [PCP Name/Clinic Name]

Fax/Phone: [PCP Contact Info]

From: [Discharging Physician/Hospital Name]

Department: [e.g., Internal Medicine/Surgery]

Patient Information

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Hospital ID: [MRN]

Dates of Admission: [Start Date] to [End Date]

Clinical Summary

Primary Diagnosis: [Main reason for hospitalization]

Secondary Diagnoses: [Other conditions treated]

Procedures: [Surgeries or major interventions performed]

Hospital Course: [Brief summary of treatment and clinical progress]

Medication Changes

New Medications: [List meds started in hospital]

Discontinued Medications: [List meds stopped]

Current Medication List: [Full list of discharge medications]

Test Results

Significant Labs/Imaging: [Key findings and pending results]

Follow-Up Plan

Required PCP Actions: [e.g., Repeat labs, wound check, titration]

Specialist Referrals: [Name of specialist and appointment date]

Discharge Status: [e.g., Stable, requiring home health, etc.]

Provider Signature: _____

Contact Number for Questions: [Phone Number]