Date: [Date]

Time: [Time]

Patient Information

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

Provider Information

From: [Sending Facility Name]
Attending Physician: [Doctor Name]
To: [Receiving Facility/Physician Name]

Clinical Summary

Reason for Transfer: [Reason]

Chief Complaint: [Primary Complaint]

History of Present Illness:
[Brief summary of symptoms and onset]

Past Medical History:
[Relevant conditions, surgeries, and allergies]

Vitals at Time of Transfer:
BP: [BP] | HR: [HR] | RR: [RR] | Temp: [Temp] | SpO2: [O2 Sat]

Physical Exam Findings:
[Key findings]

Diagnostics and Treatment

Laboratory Results: [Key lab values]

Imaging Results: [X-ray, CT, MRI summaries]

Interventions/Medications Given:
[List of medications, dosages, and procedures performed in ED]

Impression and Recommendations

Working Diagnosis: [Preliminary Diagnosis]

Stability Status: [Stable/Guarded/Critical]

Recommended Follow-up/Action:
[Pending labs or immediate needs upon arrival]

Signature: _____
Print Name: [Doctor Name/Title]
Contact Number: [Phone Number]