From: [Sending Facility/Physician Name]
Address: [Street Address, City, State, Zip]
Phone: [Phone Number]
Date: [Current Date]

To: [Receiving Facility/Physician Name]
Address: [Street Address, City, State, Zip]
Phone: [Phone Number]

PATIENT INFORMATION

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

REASON FOR TRANSFER / TRANSITION

Urgency: [Emergency / Routine Transition]
Chief Complaint/Diagnosis: [Primary reason for transfer]
Clinical Summary: [Brief description of current status and interventions performed]

CLINICAL DATA

Vital Signs (Last Recorded):
BP: [BP], HR: [HR], Temp: [Temp], SpO2: [SpO2]

Allergies: [List allergies or state NKDA]

Current Medications: [List current medications and last dose given]

Past Medical History: [List relevant chronic conditions]

RECOMMENDATIONS & FOLLOW-UP

Required Action: [e.g., Immediate stabilization, specialist consult, primary care follow-up]
Attached Documents: [ ] Lab Results [ ] Imaging Reports [ ] Medication List

Referring Provider Signature: _____
Print Name: [Provider Name]
Contact Number: [Direct Contact Number]