Date: [Insert Date]

RE: Patient Transfer of Care

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert DOB]
Medical Record Number: [Insert MRN]

TO: [Receiving Physician/Facility Name]
FROM: [Sending Physician/Facility Name]

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1. Reason for Transfer / Clinical Summary

[Briefly describe the patient's acute condition, the reason for the emergency transition, and the current clinical status.]

2. Vital Signs at Time of Transfer

- BP: [Insert BP]
- HR: [Insert HR]
- Temp: [Insert Temp]
- SpO2: [Insert SpO2]

3. Diagnosis and Medications

Primary Diagnosis: [Insert Diagnosis]

Current Medications Administered: [List medications, dosages, and times given]

4. Known Allergies

[List allergies or state "No Known Drug Allergies"]

5. Procedures and Interventions Performed

[List any emergency procedures, imaging, or labs completed prior to transfer.]

6. Coordination Requirements

[Specify immediate care needs, pending test results, or specific specialists that must be alerted upon arrival.]

7. Primary Care Physician Information

Name: [Insert PCP Name]
Phone: [Insert PCP Phone Number]
Address: [Insert Office Address]

8. Contact Information for Transferring Physician

For further clinical inquiries, please contact [Name/Department] at [Phone Number/Extension].

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]