

Date: [Date]

Recipient Name: [Receiving Therapist/Clinic Name]

Facility Name: [Facility Name]

Address: [Address]

Phone/Fax: [Phone/Fax]

RE: Transfer of Care for [Patient Name]

DOB: [Patient Date of Birth]

Surgery Date (if applicable): [Date of Surgery]

Dear [Recipient Name],

The purpose of this letter is to formally transfer the orthopedic physical therapy care of [Patient Name] to your facility effective [Date].

Diagnosis: [Primary Diagnosis and ICD-10 Code]

Clinical Summary:

The patient has completed [Number] sessions at our clinic. To date, the patient has demonstrated progress in [List Key Improvements, e.g., Range of Motion, Strength, Gait].

Current Status:

- Range of Motion: [Details]
- Muscle Strength: [Details]
- Functional Status: [Details]
- Pain Levels: [Current Pain Score]

Ongoing Plan of Care:

The current goals include [List Goals]. We recommend continuing with [Specific Interventions/Protocols] at a frequency of [Frequency] for [Duration].

Precautions:

[List Weight Bearing Status or Movement Restrictions]

Attached you will find the initial evaluation, most recent progress note, and the physician's referral. Please contact me at [Your Phone Number] or [Your Email] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name, PT/DPT]

[Your Clinic Name]