

Date: [Date]

RE: [Patient Name]

DOB: [Date of Birth]

Parent/Guardian: [Name]

Phone: [Phone Number]

To: [Receiving Therapist/Clinic Name]

From: [Sending Therapist Name], [Clinic Name]

Phone: [Sending Phone Number]

Diagnosis/Injury: [Primary Diagnosis, e.g., Distal Radius Fracture, ACL Reconstruction]

Date of Injury/Surgery: [Date]

Precautions/Weight Bearing Status: [e.g., NWB, PWB, No overhead lifting]

Clinical Summary:

[Patient Name] has been receiving physical therapy at our facility since [Start Date]. Initial presentation included [list symptoms, e.g., decreased range of motion, muscle weakness, gait abnormalities].

Current Status:

- **Range of Motion:** [Details]

- **Strength:** [Details]

- **Functional Milestones:** [e.g., Independent with crutches, return to light jogging]

Treatment Provided:

[List interventions: e.g., Manual therapy, therapeutic exercise, neuromuscular re-education, neuromuscular electrical stimulation].

Reason for Transfer:

[e.g., Patient relocation, insurance change, proximity to school].

Recommended Goals for Continued Care:

1. [Goal 1, e.g., Full return to sports]
2. [Goal 2, e.g., Bilateral symmetry in lower extremity power]
3. [Goal 3]

Please find the most recent evaluation and progress notes attached. Feel free to contact me for further clarification regarding this patient's care plan.

Sincerely,

[Signature]

[Name and Credentials]