Date: [Date]

RE: Transfer of Care for [Patient Full Name]
DOB: [Date of Birth]
Date of Surgery/Injury: [Date]

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

Clinical Summary:
The patient is a [Age]-year-old male/female transferred following [Specific Procedure, e.g., Total Hip Arthroplasty, ORIF Hip Fracture]. The hospital course was complicated by [list complications or "uneventful"]. Current medical status is stable for transition to [Sub-acute Rehab/Skilled Nursing Facility/Home Health].

Weight Bearing Status:
[e.g., Weight Bearing As Tolerated (WBAT) / Non-Weight Bearing (NWB) / Toe Touch Weight Bearing (TTWB)] on the [Left/Right] [Affected Limb].

Rehabilitation Goals:

- Functional mobility and gait training with [Assistive Device].
- Activities of Daily Living (ADL) retraining.
- Fall prevention and balance safety.
- Pain management optimization.

Current Medications:
[List medications, specifically noting Anticoagulation and Pain Management protocols].

Wound Care:
Surgical site is [e.g., closed with staples/dermabond]. Dressings should be changed [Frequency]. Staples/Sutures to be removed on [Date].

Follow-up Appointment:
Scheduled with [Physician Name] on [Date/Time] at [Location].

Contact Information:
For questions regarding this transfer, please contact [Name/Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name and Title]