

Date: [Insert Date]

TO: [Receiving Facility/Physical Therapist Name]

FROM: [Sending Therapist Name/Clinic Name]

RE: Physical Therapy Transfer Summary

PATIENT INFORMATION

Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Injury/Surgery: [Date]

DIAGNOSIS

Primary Diagnosis: [e.g., Displaced Fracture of the Right Distal Radius]

Surgical Procedure (if applicable): [e.g., ORIF with Volar Plate]

ICD-10 Code: [Insert Code]

CURRENT PRECAUTIONS & WEIGHT BEARING STATUS

Weight Bearing Status: [e.g., NWB, PWB 50%, WBAT]

Orthotic/Bracing: [e.g., CAM boot, hinged knee brace 0-90]

Other Restrictions: [Insert Restrictions]

SUMMARY OF CARE TO DATE

Total Sessions Completed: [Number]

Current Range of Motion: [Insert Measurements]

Current Strength Grade: [Insert MMT Scores]

Functional Status: [e.g., Independent with axillary crutches, requires SBA for stairs]

TREATMENT PLAN & GOALS

Active Interventions: [e.g., Manual therapy, therapeutic exercise, gait training]

Pending Goals: [Insert Goals yet to be met]

REASON FOR TRANSFER

[e.g., Patient relocation, transition to outpatient care, insurance change]

CONTACT INFORMATION

If you have any questions regarding this patient's plan of care, please contact:

Name: [Name]

Phone: [Phone Number]

Email: [Email Address]

Sincerely,

[Signature]

[Printed Name and Credentials]