Date: [Date]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number: [Worker's Comp Claim #]
Date of Injury: [Date of Injury]

To: [Receiving Therapist/Clinic Name]

Diagnosis: [Specific Orthopedic Diagnosis/ICD-10 Code]

Reason for Transfer: [e.g., Patient relocation, Change in insurance provider, Specialized equipment needs]

Current Clinical Status:

- **Subjective:** [Current pain levels, functional limitations at work]
- **Objective:** [Range of motion, strength, special test results]
- **Functional Status:** [Current work restrictions/modified duty status]

Summary of Interventions:
[List types of therapy provided: e.g., Manual therapy, Therapeutic exercise, Work hardening]

Progress Towards Goals:
[Description of improvement and remaining deficits]

Plan of Care Recommendations:
[Recommended frequency, duration, and specific focus areas for continued recovery]

Included Attachments:

- Initial Evaluation
- Most Recent Progress Note
- Current Physician Referral/Script
- Functional Capacity Evaluation (if applicable)

Sincerely,

[Signature]
[Printed Name and Title]
[Clinic Name]
[Phone Number]
[Email Address]