Date: [Date]

RE: Transfer of Care for [Patient Full Name]
Date of Birth: [Patient DOB]
Admission Date: [Date of Admission]
Discharge/Transfer Date: [Date of Transfer]

To: [Receiving Facility/Provider Name]
Attention: [Contact Person/Admissions Department]
Address: [Receiving Facility Address]

Dear [Name of Contact or Provider],

This letter serves as formal documentation for the transfer of care of [Patient Name] from [Your Facility Name] to [Receiving Facility Name].

Primary Diagnoses:

- [Substance Use Disorder Diagnosis]
- [Co-occurring Mental Health Diagnosis, if applicable]
- [Relevant Medical Conditions]

Clinical Summary:
During their stay at our facility, the patient completed [Number] days of [Level of Care, e.g., Residential Treatment]. The patient participated in individual therapy, group counseling, and [List other interventions, e.g., family therapy, academic support].

Current Medications:

- [Medication Name, Dosage, and Frequency]
- [Medication Name, Dosage, and Frequency]

Reason for Transfer:
[Reason, e.g., Transition to a lower level of care, specialized dual-diagnosis treatment, or proximity to family].

Risk Assessment:
At the time of transfer, the patient is clinically stable.
Suicidal/Homicidal Ideation: [None / Minimal / See Notes]
Withdrawal Risk: [Low / Managed / Completed Detox]

Attachments Included:

- Discharge Summary
- Recent Physical Exam and Lab Results
- Immunization Records

- Initial Bio-Psychosocial Assessment

Please contact us at [Phone Number] or [Email Address] if you require additional information regarding this transition.

Sincerely,

[Signature]
[Printed Name]
[Title/Credential]
[Your Facility Name]