Date: [Date]

RE: Transfer of Care

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Contact Information: [Phone Number]

To: [Receiving Physician Name]
Facility: [Receiving Clinic/Hospital Name]

Dear Dr. [Last Name],

I am writing to formally transfer the gastroenterological care of [Patient Name] to your practice effective [Date]. This transfer is due to [Reason for Transfer: e.g., patient relocation, transition to adult care, or insurance changes].

Primary Diagnosis:
[Insert Primary Diagnosis, e.g., Crohn's Disease, GERD, Cirrhosis]

Clinical History and Current Status:
[Brief summary of disease progression, current symptoms, and most recent clinical assessment.]

Current Medications:
[List medication names, dosages, and frequencies]

Recent Diagnostic Results:

- **Endoscopy/Colonoscopy:** [Date and Key Findings]
- **Imaging (CT/MRI/Ultrasound):** [Date and Key Findings]
- **Laboratory Results:** [Pertinent recent blood work, e.g., LFTs, CBC, CRP]

Pending Actions/Follow-up Plan:
[List any upcoming tests, biopsies pending, or recommended follow-up intervals.]

Relevant medical records, procedure reports, and pathology results are [enclosed/available via EMR].

Thank you for assuming the care of this patient. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic Name/Department]