Date: [Date]

To: [Primary Care Physician Name]
Clinic: [PCP Clinic Name]
Fax/Address: [PCP Contact Details]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Procedure Date: [Date of Procedure]

Dear Dr. [PCP Last Name],

This patient was seen at [Facility Name] for a [Procedure Type: e.g., Colonoscopy/EGD]. The procedure was completed successfully, and the patient is being transferred back to your primary care for ongoing management.

Indication:
[Reason for procedure/Symptoms]

Key Findings:
[Brief summary of findings or "See attached report"]

Interventions/Biopsies:
[List any biopsies taken or polyps removed]

Immediate Plan:

- [Medication changes, if any]
- [Dietary or activity restrictions]
- [Pathology follow-up timeline]

Recommended Follow-up:
[Next procedure interval: e.g., Repeat in 5 years / Routine screening]

Full procedure and pathology reports (when available) will be forwarded to your office. Please contact our department at [Phone Number] if you have any questions.

Sincerely,

[Gastroenterologist Name]
[Department/Clinic Name]