Date: [Date]

To: Outpatient Endoscopy Department / Scheduling Team
From: [Ordering Physician/Unit Name]
Facility: [Hospital Name]

SUBJECT: TRANSFER OF ENDOSCOPY PROCEDURE FROM INPATIENT TO OUTPATIENT

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

PROCEDURE REQUESTED:
[e.g., Colonoscopy, EGD, Sigmoidoscopy]

CLINICAL INDICATION:
[Reason for procedure and brief clinical history]

TRANSFER STATUS:
The above patient was initially scheduled for this procedure as an inpatient on [Date]. However, the patient has been deemed clinically stable for discharge. We are requesting this procedure be transitioned to an outpatient setting.

URGENCY:
[ ] Routine (Within 4-6 weeks)
[ ] Urgent (Within 1-2 weeks)
[ ] High Priority (As soon as possible)

SPECIAL CONSIDERATIONS:
Anticoagulation: [Yes/No] - [Instructions]
Sedation Requirements: [Standard/Anesthesia/MAC]
Mobility Issues: [Yes/No]

REFERRING PHYSICIAN SIGNATURE:

_____
[Physician Name]
[Pager/Contact Number]