Date: [Insert Date]

To: [Primary Care Physician Name]
Facility: [Clinic/Practice Name]
Address: [Street Address, City, State, Zip]

RE: Transfer of Care - Cardiovascular Rehabilitation Completion
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Diagnosis: Chronic Heart Failure (NYHA Class [I-IV])

Dear Dr. [Physician Last Name],

This letter is to formally transfer the cardiovascular care of the above-named patient back to your primary management following the completion of their Cardiac Rehabilitation program.

Clinical Summary:
The patient participated in [Number] sessions of supervised aerobic and resistance training. Throughout the program, the patient remained clinically stable and demonstrated improved functional capacity.

Outcome Measures:

- **6-Minute Walk Test:** [Initial Distance] meters to [Final Distance] meters.
- **Resting Heart Rate:** [BPM]
- **Resting Blood Pressure:** [mmHg]
- **Weight/BMI:** [Current Status]

Medication Regimen:
The patient is currently stable on the following GDMT (Guideline-Directed Medical Therapy): [List Medications and Dosages]

Discharge Recommendations:

- Continue home-based exercise program (30-45 minutes, 5 days per week).
- Adhere to a low-sodium diet and daily weight monitoring.
- Follow up with Cardiology in [Number] months.
- Monitor for signs of fluid overload (edema, increased dyspnea).

Please contact our department at [Phone Number] if you require further clinical details or if the patient's status changes significantly.

Sincerely,

[Your Name/Signature]
[Title/Position]
[Cardiovascular Rehabilitation Department Name]