**[Date]**

**To:** [Receiving Facility Name]
**Attention:** Cardiovascular Rehabilitation Department
**Address:** [Recipient Street Address]
**City, State, Zip:** [City, State, Zip Code]

**RE: TRANSFER OF CARE DUE TO CLINIC RELOCATION**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [MM/DD/YYYY]
**Medical Record Number:** [MRN]

Dear Cardiovascular Rehabilitation Team,

This letter serves as a formal transfer of care for the above-named patient. Due to the relocation of **[Current Clinic Name]**, this patient is being transitioned to your facility for continued cardiovascular rehabilitation services effective **[Effective Date]**.

**Clinical Summary:**

- **Primary Diagnosis:** [e.g., Post-MI, CABG, Stent Placement]
- **Procedure Date:** [Date]
- **Current Phase of Rehab:** [Phase II/Phase III]
- **Sessions Completed:** [Number] of [Total Authorized]
- **Comorbidities:** [List relevant conditions]

**Functional Status:**

- **Last Exercise Stress Test Date:** [Date]
- **Metabolic Equivalents (METs) Achieved:** [Value]
- **Current Exercise Prescription:** [Specify intensity, duration, and frequency]
- **Target Heart Rate Range:** [BPM] to [BPM]

**Medications:**
[List current medications or see attached list]

Attached to this letter are the patient's most recent progress notes, ECG strips, intake assessment, and insurance authorization details. The patient's next scheduled session is **[Date/Time]** at your location.

If you require further clinical information, please contact our office at **[Phone Number]** before our final closing date of **[Closing Date]**.

Sincerely,

[Signature]
**[Printed Name]**
[Title/Credentials]
[Current Clinic Name]