Date: [Insert Date]

RE: [Patient Full Name]
DOB: [Date of Birth]
ID Number: [Patient ID/Reference Number]

To: Admissions Department / Rehabilitation Coordinator
Facility Name: [Receiving Rehabilitation Clinic Name]
Address: [Clinic Address]

Dear Clinical Team,

I am writing to formally transfer the care of [Patient Name] to your facility for inpatient/outpatient rehabilitation services. The patient has been under my care at [Primary Care Clinic Name] for [Duration of Time].

Primary Diagnosis: [Main Reason for Rehabilitation]

Secondary Diagnoses:

- [Condition 1]
- [Condition 2]

Clinical Summary:
[Provide brief history of the acute event, recent surgery, or functional decline necessitating rehab. Include baseline mobility and current limitations.]

Medications:
[List current medications or state "See attached medication administration record"]

Allergies:
[List allergies or state "No Known Drug Allergies"]

Rehabilitation Goals:
[Specify goals: e.g., improved gait, ADL independence, pain management, speech therapy]

Social Situation:
[Living situation, caregiver support, and planned discharge destination]

Please find the attached medical records, recent lab results, and imaging reports. I remain available for any further information required for this transition.

Sincerely,

[Doctor Signature]
[Doctor Printed Name]

[Provider Title]
[Clinic Name]
[Phone Number]
[Email Address]