Date: [Insert Date]

TO: Admissions Department / Medical Director
Facility Name: [Insert Rehabilitation Center Name]
Address: [Insert Center Address]

RE: Transfer of Care
Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Date of Admission: [Insert Date]
Date of Discharge: [Insert Date]

Dear Medical Staff,

The patient named above is being transferred to your facility for continued recovery and cardiac rehabilitation following treatment for [Insert Primary Cardiac Diagnosis, e.g., Acute Myocardial Infarction].

Clinical Summary:
The patient underwent [Insert Procedure, e.g., PCI to LAD, CABG, or Valve Replacement] on [Insert Date]. The hospital course was [Stable/Complicated by...]. Recent echocardiogram dated [Date] showed an LVEF of [Percentage]%.

Current Medications:
[Insert List of Medications, focusing on Antiplatelets, Beta-blockers, ACE inhibitors, and Statins]

Cardiac Parameters and Restrictions:

- **Weight Monitoring:** [e.g., Daily weights; notify MD if >3lbs gain in 24hrs]
- **Blood Pressure Goal:** [e.g., Less than 130/80 mmHg]
- **Heart Rate Goal:** [e.g., 60-100 bpm]
- **Activity Level:** [e.g., Cardiac rehab phase 1, weight bearing as tolerated]
- **Diet:** [e.g., Heart Healthy / Low Sodium]

Follow-up Plan:
The patient is scheduled for a follow-up appointment at my office on [Date/Time]. Please ensure transportation is arranged or the family is notified.

Please contact my office at [Insert Phone Number] if there are any acute changes in cardiac status or questions regarding the treatment plan.

Sincerely,

[Signature]
[Doctor Name, MD/DO]

[Clinic/Hospital Name]
[Contact Information]