Date: [Date]

To: [PCP Name]
Clinic Name: [Clinic Name]
Fax/Address: [PCP Fax Number or Address]

RE: Return of Care / Transition of Care Summary

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Service: [Date Range of Specialist Care]

Dear Dr. [PCP Last Name],

Thank you for referring [Patient Name] to our office for [Reason for Referral/Specialty Care]. We have completed our specialized treatment/consultation, and the patient is now being transitioned back to your primary care for ongoing management.

Summary of Care:
[Brief description of diagnosis, procedures performed, or treatment provided]

Current Status:
[Stable / Improving / Resolved]

Ongoing Recommendations:

- [Recommendation 1]
- [Recommendation 2]
- [Medication changes, if any]

Follow-up Plan:
The patient has been instructed to schedule a follow-up appointment with your office within [Timeframe]. We have scheduled a PRN follow-up with our specialty clinic in [Months/Year].

All relevant clinical notes and test results are attached for your records. If you have any questions regarding this transition, please contact our office at [Your Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title/Specialty]
[Your Clinic Name]