

Date: [Insert Date]

RE: Transfer of Care for Opioid Therapy

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

To: [Receiving Provider/Clinic Name]

Dear Dr. [Provider Last Name],

The purpose of this letter is to formally transfer the management of chronic opioid therapy for the above-named patient to your care, effective [Effective Date].

**Diagnosis and Indication:**

The patient is being treated for [Specific Chronic Pain Diagnosis]. Opioid therapy has been initiated as part of a comprehensive pain management plan.

**Current Medication Regimen:**

- Medication Name: [e.g., Morphine ER]
- Dosage: [e.g., 15mg]
- Frequency: [e.g., Twice Daily]
- Total Daily Morphine Milligram Equivalents (MME): [Insert Total MME]

**Treatment History and Compliance:**

The patient has been under my care for this condition since [Start Date]. Attached you will find:

- The most recent Prescription Monitoring Program (PMP) report.
- The most recent Urine Drug Screen (UDS) results dated [Date].
- A copy of the signed Controlled Substance Provider-Patient Agreement.
- Recent clinical progress notes documenting functional goals and efficacy.

**Reason for Transfer:**

[Insert Reason, e.g., Patient relocation, Specialty transfer, Transition to primary care].

I have provided the patient with a final bridge prescription lasting until [Date]. Please contact my office at [Phone Number] if you require additional clinical documentation regarding this transition.

Sincerely,

[Signature]

[Printed Name and Credentials]

[Clinic Name]

[Contact Information]