

**Date:** [Date]

**RE: Patient Transfer of Care**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Hospital/ID Number:** [ID Number]

**To:** [Receiving Clinician Name / Primary Care Physician]

**From:** [Performing Clinician Name], [Department]

**1. Procedure Details**

- **Procedure Performed:** [Name of Procedure]
- **Date of Procedure:** [Date]
- **Indications:** [Reason for Procedure]
- **Outcome:** [Success/Findings/Technical Results]

**2. Medications & Anesthesia**

- **Sedation/Anesthesia Used:** [Type and Drugs]
- **Intra-procedural Medications:** [e.g., Heparin, Contrast type/volume]
- **New Medications Prescribed:** [Drug Name, Dosage, Duration]

**3. Post-Procedural Care & Instructions**

- **Access Site Care:** [e.g., Groin/Radial site instructions, suture removal date]
- **Activity Restrictions:** [e.g., Heavy lifting, driving, return to work]
- **Monitoring Requirements:** [e.g., Blood pressure, lab work, wound checks]

**4. Follow-Up Plan**

The patient has been instructed to follow up with [Clinic/Doctor Name] on [Date/Timeframe]. Further imaging or testing is scheduled for [Date].

**5. Red Flags / When to Seek Urgent Care**

The patient should seek immediate medical attention if they experience: [e.g., Bleeding at site, fever, severe pain, shortness of breath].

**6. Contact Information**

For any clinical queries regarding this procedure, please contact [Department Name] at [Phone Number].

Sincerely,

[Signature]

[Printed Name and Title]