

Date: [Date]

To:

[Receiving Specialist Name]

[Department/Clinic Name]

[Address]

[City, State, Zip Code]

From:

[Referring Provider Name]

[Clinic Name]

[Contact Information]

RE: Transfer of Care / Specialist Referral

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/MRN: [ID Number]

Dear Dr. [Specialist Last Name],

I am writing to formally refer the above-named patient to your care for management of [Specific Condition/Diagnosis].

Reason for Referral:

[Detailed reason for transfer and clinical goals].

Clinical Summary:

[Brief medical history, current symptoms, and duration of condition].

Current Medications:

[List of relevant medications and dosages].

Relevant Test Results:

[Summary of recent labs, imaging, or biopsies attached/enclosed].

Treatment Provided to Date:

[Summary of interventions or surgeries already performed].

I have discussed this transfer with the patient, and they are in agreement. Please find the attached medical records for your review. I am available for any questions regarding this patient's history.

Thank you for participating in this patient's care.

Sincerely,

[Signature]
[Printed Name]
[Credentials]
[NPI Number]