Date: [Insert Date]

RE: Patient Transfer of Care
Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert DOB]
Medical Record Number: [Insert MRN]

To: [Receiving Physician/Facility Name]
Department: [Insert Department]
Address: [Insert Address]

Dear [Recipient Name],

The purpose of this letter is to formally transfer the medical care of the above-named patient to your practice/facility effective [Insert Date].

Reason for Transfer:
[Insert reason, e.g., relocation, specialist consultation, or transition to long-term care]

Current Diagnoses & Medical History:
[List primary and secondary diagnoses]

Current Medications & Allergies:
[List active medications, dosages, and known drug allergies]

Recent Treatments & Procedures:
[Brief summary of recent interventions or hospitalizations]

Pending Results & Follow-up Actions:
[List any outstanding laboratory tests, imaging, or scheduled appointments]

Attached to this letter, you will find the patient's comprehensive medical records, including recent lab results and immunization history. Please contact our office at [Insert Phone Number] if you require additional information to ensure a seamless transition for the patient.

Sincerely,

[Signature]
[Physician Name, Title]
[Practice/Facility Name]
[Contact Information]