Date: [Date of Issue]

Recipient Name: [Receiving Provider/GP Name]
Facility/Clinic: [Facility Name]
Address: [Address Line 1], [City, State, Zip]

RE: DISCHARGE AND TRANSFER OF CARE

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]
Admission Date: [Date]
Discharge Date: [Date]

1. Clinical Summary:
[Brief description of reason for admission, hospital course, and procedures performed.]

2. Final Diagnosis:
[List primary and secondary diagnoses.]

3. Condition at Discharge:
[Describe physical and mental state, e.g., Stable, Improving, Guarded.]

4. Medication Summary:
[List medications to be continued, new prescriptions, and any medications stopped.]

5. Follow-up Plan and Recommendations:
[List upcoming appointments, pending test results, and specific care instructions.]

6. Reason for Transfer:
[Specify if transferring for step-down care, rehabilitation, or specialist management.]

Please contact our department at [Phone Number] if you require further clinical details regarding this transition of care.

Sincerely,

Signature: _____
Printed Name: [Discharging Clinician Name]
Title/Designation: [Title]
Organization: [Hospital/Clinic Name]