Date: [Date]

From:
[Referring Clinician Name]
[Current Clinic/Facility Name]
[Address]
[Phone Number]
[Email]

To:
[Receiving Clinician/Clinic Name]
[Facility Name]
[Address]

RE: Transfer of HIV Care

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

Dear [Receiving Clinician Name],

This letter is to formally transfer the HIV clinical management of the above-named patient to your care, effective [Transfer Date]. The patient is relocating/requesting transfer due to [Reason].

Clinical Summary:

- **Date of HIV Diagnosis:** [Date]
- **Estimated Date of Infection:** [Date, if known]
- **Baseline Viral Load/CD4:** [Values]
- **Most Recent CD4 Count:** [Value] cells/mm (Date: [Date])
- **Most Recent Viral Load:** [Value] copies/mL (Date: [Date])
- **Hepatitis B/C Status:** [Status]
- **Drug Resistance Testing:** [Results/None]

Current Antiretroviral Therapy (ART):

- Regimen: [List Medications and Dosages]
- Date Started Current Regimen: [Date]
- Adherence Status: [Good/Fair/Poor]
- Known Medication Allergies: [Allergies]

Past Medical History & Comorbidities:
[List relevant conditions, e.g., hypertension, mental health, opportunistic infections]

Current Non-HIV Medications:
[List other medications]

Last Pharmacy Refill: [Date]
Next Scheduled Appointment: [Date/Time]

Attached are the most recent laboratory results and clinical notes for your review. Please contact our office if you require further information regarding this patient's history.

Sincerely,

[Signature]
[Name and Title]