Date: [Insert Date]

To: [Receiving Facility/Physician Name]
Department: [Department Name]
Facility Address: [Address, City, State, Zip]

RE: Outpatient Parenteral Antimicrobial Therapy (OPAT) Transfer
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

---

1. Diagnosis and Clinical History

Primary Infection: [e.g., Osteomyelitis, Endocarditis, Bacteremia]

Pathogen(s) Identified: [Insert Culture Results/Sensitivity]

Summary of Treatment to Date: [Brief history of surgical intervention or prior therapy]

2. Current Antimicrobial Regimen

Medication: [Drug Name]

Dosage: [e.g., 2g]

Frequency: [e.g., Every 12 hours / Once Daily]

Administration Method: [e.g., Gravity, IV Pump, Bolus]

Treatment Start Date: [Date]

Planned Completion Date: [Date] (Total Duration: [Number] weeks)

3. Vascular Access Data

Line Type: [e.g., PICC line, Midline, Port-a-cath]

Insertion Date: [Date]

Anatomical Location: [e.g., Right Upper Arm]

Care Required: [e.g., Weekly dressing changes, Heparin/Saline flushes per protocol]

4. Monitoring and Follow-up

Required Lab Work: [e.g., CBC, CRP, Creatinine, Vancomycin Trough Levels]

Frequency of Labs: [e.g., Weekly every Tuesday]

Next Scheduled Clinic Appointment: [Date and Time]

5. Provider Contact Information

Referring Physician: [Name]
Office Phone: [Phone Number]
After-Hours/Emergency Contact: [Phone Number]
Infectious Disease Consultant: [Name and Contact]

Sincerely,

[Signature]
[Printed Name and Title]