Date: [Insert Date]

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

RE: Patient Transfer of Care for Surgical Site Infection (SSI)

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Medical Record Number: [Insert MRN]

1. Original Procedure Details:
Primary Surgery: [Insert Procedure Name]
Date of Surgery: [Insert Date]
Operating Surgeon: [Insert Surgeon Name]

2. Infection Presentation:
Date of Infection Onset: [Insert Date]
Diagnosis: [Superficial / Deep Incisional / Organ Space] SSI
Clinical Signs: [e.g., Erythema, purulent drainage, dehiscence, fever]

3. Microbiology & Diagnostics:
Culture Date: [Insert Date]
Pathogen(s) Identified: [Insert Pathogens or 'Pending']
Sensitivity Results: [Insert Key Sensitivities]
Imaging Results: [Insert Summary of CT/Ultrasound findings]

4. Treatment Provided to Date:
Surgical Intervention: [e.g., I&D, Debridement, Washout]
Current Antibiotic Regimen: [Drug Name, Dosage, Frequency, Start Date]
Wound Care: [e.g., Vacuum-assisted closure (VAC), packing, dressing type]

5. Transfer Plan & Requirements:
Reason for Transfer: [e.g., Specialized wound care, long-term IV antibiotics, proximity to home]
Pending Lab Results: [Insert pending items]
Follow-up Instructions: [Insert dates for next surgical review]

Provider Contact Information:
Referring Clinician: [Insert Name]
Phone Number: [Insert Phone]
Email: [Insert Email]

Sincerely,

[Signature]
[Printed Name and Title]