

Date: [Date]

To: [Neurology Clinic Name/Physician Name]

From: [Acute Stroke Unit Name/Attending Physician]

RE: Transfer of Care / Post-Stroke Follow-up

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Admission: [Admission Date]

Date of Discharge: [Discharge Date]

Diagnosis:

[Type of Stroke: e.g., Acute Ischemic Stroke / Intracranial Hemorrhage]

[Location/Vessel Involved]

[Etiology: e.g., Cardioembolic, Large Artery Atherosclerosis]

Hospital Course Summary:

[Brief summary of acute interventions: e.g., tPA administered, Thrombectomy, or medical management]. [List significant complications or lack thereof].

Diagnostic Results:

- MRI/CT Brain: [Key findings]

- Vascular Imaging (CTA/MRA): [Key findings]

- Echocardiogram: [Key findings]

- Telemetry/Holter: [Key findings]

Current Medications:

[List antiplatelets, anticoagulants, statins, and antihypertensives]

Neurological Status at Discharge:

NIH Stroke Scale (NIHSS) at Discharge: [Score]

Modified Rankin Scale (mRS): [Score]

Deficits: [Brief description of residual weakness, aphasia, etc.]

Follow-up Requirements:

- Repeat Imaging: [Date/Type if needed]

- Lab Work: [Lipid panel, HbA1c, etc.]

- Referrals: [Physical Therapy, Occupational Therapy, Speech Therapy]

Plan/Recommendations:

[Specific instructions for the outpatient neurologist regarding medication titration or further workup].

Sincerely,

[Physician Signature]

[Physician Name and Title]

[Contact Information/Phone Number]