Date: [Insert Date]

To: Attending Physician / Stroke Team
Facility: [Insert Specialized Stroke Center Name]

RE: URGENT TRANSFER OF PATIENT

Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
Sex: [Insert Sex]
Last Known Well (Time/Date): [Insert Time/Date]

Dear Stroke Team,

This letter is to facilitate the emergent transfer of the above-named patient for suspected acute cerebrovascular accident (CVA) and higher level of care.

Clinical Presentation:
[Briefly describe symptoms: e.g., facial drooping, slurred speech, right-sided weakness].

Vital Signs at Transfer:
BP: [00/00] | HR: [00] | RR: [00] | SpO2: [00%] | Glucose: [000]

Interventions Performed:
[List interventions: e.g., IV access established, Oxygen started, Aspirin held/given].

Medical History:
[List relevant history: e.g., Hypertension, Atrial Fibrillation, Diabetes].

Current Medications:
[List medications, specifically noting anticoagulants or antiplatelets].

Allergies:
[List allergies or state NKDA]

Contact Information:
Referring Physician: [Insert Name]
Phone Number: [Insert Phone]
Next of Kin Contact: [Insert Name/Phone]

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Facility Name]