Date: [Date]

RE: Patient Transfer of Care
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Stroke: [Date of Incident]
Diagnosis: [Type of Stroke, e.g., Ischemic/Hemorrhagic L/R Hemisphere]

To [Receiving Therapist/Facility Name],

This letter serves to formally transfer the care of the above-named patient for continued Occupational Therapy (OT) and Physical Therapy (PT) services.

1. Clinical Status & Impairments

- **Motor Function:** [e.g., Hemiparesis of right side, muscle tone, ROM limits]
- **Mobility:** [e.g., Current ambulation status, assistive devices used]
- **ADLs:** [e.g., Level of independence with dressing, grooming, feeding]
- **Cognition/Communication:** [e.g., Aphasia status, following commands, safety awareness]

2. Current Therapy Progress

Physical Therapy: [Summarize recent goals met and current functional gait/balance status]

Occupational Therapy: [Summarize progress in fine motor skills and upper extremity integration]

3. Current Assistive Technology / Equipment

[List wheelchairs, braces/AFOs, walkers, or adaptive tools currently in use]

4. Recommended Plan of Care

We recommend the following frequency and focus for continued rehabilitation:

- **PT Frequency:** [e.g., 2-3x per week] focusing on [Goal]
- **OT Frequency:** [e.g., 2-3x per week] focusing on [Goal]

Please find the attached formal evaluation reports and daily notes for detailed clinical data. Should you require further information, please contact our office at [Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title/Credential]
[Facility Name]