Date: [Insert Date]

To: [Receiving Facility Name/Physician Name]
From: [Sending Facility Name/Physician Name]
Subject: Continuation of Care Transfer Letter

Patient Identification

Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Date of Admission: [Admission Date]
Date of Transfer: [Transfer Date]

Primary Diagnosis

Acute Ischemic Stroke ([Location of Infarct/Artery Involved])

Clinical Summary

Initial Presentation: [Brief description of symptoms and NIHSS score at arrival].

Acute Interventions: [tPA Administered: Yes/No] | [Thrombectomy: Yes/No] | [Relevant Procedures].

Hospital Course: [Summarize stability, neurological improvements, or complications].

Current Status

Neurological Status: [Current NIHSS or functional deficits].
Vital Signs: [BP Range and Stability].
Swallow Status: [Pass/Fail Swallow Screen] | [Diet Texture].
Mobility: [Assistance level needed for ambulation/transfer].

Ongoing Medications

- Antiplatelet/Anticoagulant: [Drug Name and Dosage]
- Statin Therapy: [Drug Name and Dosage]
- Antihypertensives: [Drug Name and Dosage]
- Other: [List significant medications]

Recommended Care Plan

Rehabilitation Goals: [PT/OT/Speech Therapy goals].
Follow-up Imaging: [Scheduled MRI/CT/Carotid Doppler].
Special Precautions: [Fall risk, Aspiration risk, DVT prophylaxis].

Contact Information

For questions regarding this transfer, please contact [Name/Department] at [Phone Number].

Sincerely,

[Signature]
[Printed Name and Title]