Date: [Insert Date]

To: Admissions Department / Medical Director
Facility Name: [Insert Receiving Facility Name]
Address: [Insert Facility Address]

RE: Patient Transfer Letter
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Date of Admission: [Insert Admission Date]
Date of Transfer: [Insert Transfer Date]

Diagnosis: Hemorrhagic Stroke (Intracerebral/Subarachnoid Hemorrhage)

Clinical Summary:
The patient was admitted following a hemorrhagic stroke involving the [Insert Location of Bleed, e.g., Left Basal Ganglia]. Initial management included [Insert Interventions, e.g., BP management, surgical evacuation, or EVD placement]. The acute phase is now resolved, and the patient is medically stable for transfer to a long-term care facility for continued recovery and rehabilitation.

Current Neurological Status:
[Insert details regarding alertness, orientation, and speech/language deficits].

Physical and Functional Status:
- **Mobility:** [e.g., Bedbound, requires assist of 2 for transfers]
- **Motor Deficits:** [e.g., Right-sided hemiplegia]
- **Swallow Status:** [e.g., NPO, Dysphagia diet, or G-tube dependent]

Ongoing Care Requirements:
- **Medications:** See attached Medication Administration Record (MAR). Focus on antihypertensive management.
- **Therapies:** Requires ongoing Physical, Occupational, and Speech Therapy.
- **Nursing Care:** [e.g., Wound care, catheter care, or respiratory monitoring].

Code Status: [Full Code / DNR / DNI]

Contact Information:
For medical questions regarding this transfer, please contact [Insert Physician Name] at [Insert Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title]
[Hospital/Unit Name]