Date: [Insert Date]

RE: Patient Transfer Report
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury/Stroke: [Date of Incident]

To: [Receiving Facility/Provider Name]

1. Diagnosis and History

The patient was admitted following a [Ischemic/Hemorrhagic] stroke affecting the [Location, e.g., Left MCA territory]. Primary deficits include [Aphasia/Dysarthria/Apraxia] and cognitive-linguistic impairment.

2. Current Speech and Language Status

Communication: [Describe current ability, e.g., non-verbal, telegraphic speech, or fluent with paraphasias].
Comprehension: [Level of auditory processing and command following].
Expression: [Naming, repetition, and spontaneous speech capabilities].

3. Cognitive Rehabilitation Status

Attention: [Sustained/Selective/Divided attention levels].
Memory: [Short-term, long-term, and working memory status].
Executive Function: [Problem solving, sequencing, and safety awareness].

4. Swallowing (Dysphagia) Status

Current Diet: [e.g., Minced and Moist / Slightly Thick liquids].
Aspiration Risk: [Low/Medium/High].
Compensatory Strategies: [e.g., Chin tuck, double swallow].

5. Treatment Goals and Recommendations

- Continue intensive [Speech/Language/Cognitive] therapy [Number] times per week.
- Focus on [Specific Goal, e.g., functional communication or memory aids].
- Monitor for [Signs of depression or fatigue].

6. Discharge/Transfer Disposition

The patient is being transferred to [Facility Name] for continued [Inpatient/Outpatient] rehabilitation services.

Sincerely,

[Signature]
[Printed Name and Credentials]
[Facility Name/Department]
[Contact Phone/Email]