

**Date:** [Insert Date]

**RE:** Patient Transfer of [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

**To:** Admissions Department / Nursing Supervisor

**Receiving Facility:** [Name of Skilled Nursing Facility]

**From:** [Sending Physician/Provider Name], [Sending Hospital Name]

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## 1. Transfer Summary

The patient is being transferred for continued skilled nursing care and complex neurological rehabilitation following [Primary Diagnosis/Event, e.g., Traumatic Brain Injury, Stroke, Status Post Neurosurgery].

## 2. Neurological Status & Deficits

- **Baseline Mental Status:** [e.g., Alert, Obtunded, Minimally Conscious State]
- **Cognitive Impairments:** [e.g., Memory loss, Aphasia, Executive dysfunction]
- **Motor Function:** [e.g., Left-sided hemiplegia, Quadriparesis]
- **Seizure History:** [Yes/No - include frequency and last seizure date]
- **Communication:** [e.g., Non-verbal, uses communication board, follows simple commands]

## 3. Specialized Care Requirements

- **Airway Management:** [e.g., Tracheostomy size/type, Ventilator settings, Suctioning frequency]
- **Nutrition/Hydration:** [e.g., PEG tube, G-Tube, NPO status, Formula type and rate]
- **Skin Integrity:** [e.g., Stage III Pressure Injury to sacrum, Incision care]
- **Neurogenic Bladder/Bowel:** [e.g., Indwelling catheter, Scheduled bowel program]

## 4. Current Medications

Please refer to the attached Medication Administration Record (MAR). Note specifically the scheduling of:

- Antiepileptic Drugs (AEDs)
- Spasticity Management (e.g., Baclofen)
- Neuropathic Pain Medications
- Anticoagulation Therapy

## 5. Rehabilitation Goals

- Physical Therapy: [e.g., Contracture prevention, Assisted transfers]
- Occupational Therapy: [e.g., ADL training, Splinting]
- Speech Therapy: [e.g., Swallowing evaluation, Cognitive therapy]

## **6. Code Status & Advance Directives**

**Code Status:** [Full Code / DNR / DNI]

**Health Care Proxy:** [Name and Contact Number]

## **7. Contact Information**

For clinical questions regarding this transfer, please contact: [Provider Name] at [Phone Number].

Sincerely,

[Signature]

[Printed Name and Title]