Date: [Date]

RE: Patient Referral and Medication Transfer
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Patient Phone: [Patient Phone Number]

To: [Specialist Name/Clinic Name]
Address: [Specialist Address]
Phone/Fax: [Specialist Phone/Fax]

Dear [Specialist Name],

I am referring [Patient Name] to your care for management of [Specific Condition/Diagnosis]. The patient has been under my care since [Date] and requires specialist intervention for [Reason for Referral].

Current Controlled Substance Regimen:
The patient is currently prescribed the following controlled medication(s) for the treatment of [Condition]:

- **Medication:** [Drug Name and Strength]
- **Dosage:** [Frequency/Instructions]
- **Quantity:** [Amount per Month]
- **Date of Last Prescription:** [Date]
- **Last PDMP Review Date:** [Date]

Reason for Transfer of Prescribing Responsibility:
[Reason, e.g., Long-term pain management requirements, psychiatric stabilization, or specialized monitoring].

Documentation Included:
Attached you will find the patient's recent progress notes, relevant laboratory results, diagnostic imaging, and our signed Controlled Substance Treatment Agreement.

I have informed the patient that as of [Transfer Date], [Specialist Name/Clinic] will assume full responsibility for the assessment, monitoring, and prescribing of the above-mentioned controlled substances. I will continue to manage the patient's general medical needs.

Please contact my office at [Phone Number] if you require further clinical information or clarification regarding this transfer.

Sincerely,

[Physician Signature]
[Physician Name, Title]

[Clinic Name]
[DEA Number (Optional)]