

Date: [Insert Date]

To: [Receiving Facility/Physician Name]

Department: [Insert Department Name]

Address: [Insert Address]

RE: Patient Imaging Transfer

Patient Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/MRN: [Insert ID Number]

Dear [Recipient Name],

Please find enclosed the diagnostic imaging records for the above-mentioned patient, who is being transferred to your care for [Reason for Transfer/Continued Consultation].

Imaging Studies Included:

- [Study Type, e.g., Chest CT Scan] - [Date Performed]
- [Study Type, e.g., Brain MRI] - [Date Performed]
- [Study Type, e.g., Ultrasound] - [Date Performed]

Clinical Indication/History:

[Insert brief clinical summary and the reason the imaging was ordered]

Radiology Findings Summary:

[Insert key findings or attach formal radiology reports]

Transfer Media Format:

- Electronic Transfer (PACS/Cloud Share)
- Physical Media (CD/DVD/USB Attached)
- Hard Copy Films

If you require further information or have difficulty accessing the digital files, please contact our Imaging Department at [Phone Number] or [Email Address].

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Position]

[Originating Facility Name]