**Date:** [Date]

**TO:** [Receiving Provider Name/Clinic]
**Address:** [Receiving Clinic Address]
**Phone/Fax:** [Receiving Phone/Fax Number]

**RE: Continuity of Care and Transfer of Records**
**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient Date of Birth]
**EDD (Estimated Due Date):** [Date, if applicable]

Dear Dr. [Provider Last Name],

This letter is to formally transfer the obstetric and gynecological care of the above-named patient to your practice, effective [Transfer Date]. The patient is transitioning care due to [Reason, e.g., relocation/insurance change/patient preference].

**Clinical Summary:**

- **Current Pregnancy Status:** [Gaps/Paras, current gestational age, and progress]
- **Significant Medical History:** [Relevant conditions, e.g., Gestational Diabetes, Hypertension]
- **Surgical History:** [Previous C-sections, LEEP, etc.]
- **Current Medications:** [List medications and dosages]
- **Allergies:** [List allergies]

**Enclosed Records:**

- Prenatal Flowsheets and Initial OB Workup
- Recent Ultrasound Reports (including Anatomy Scan)
- Laboratory Results (NIPT, GTT, CBC, Blood Type/Rh, STI Screening)
- Most Recent Pap Smear and Pathology Reports
- Immunization Records (Tdap, Flu, etc.)

The patient's last visit was on [Date of Last Visit]. Her next scheduled/recommended follow-up is [Date or Frequency].

Please contact our office at [Your Phone Number] if you require any further clarification or additional documentation regarding this patient's history.

Sincerely,

[Provider Signature]
[Provider Name and Title]
[Clinic Name]