Summary of Care Transition

Date: [Insert Date]

To: [Specialist's Name]

From: [Primary Care Provider's Name]

Practice: [Practice Name]

Contact Information: [Phone Number, Email Address]

Patient Information

Patient Name: [Patient's Name]

Date of Birth: [Patient's DOB]

Patient ID: [Patient ID]

Reason for Referral

[Insert reason for referral and any relevant clinical findings]

Medical History

[Summarize relevant medical history, including diagnoses, medications, and allergies]

Current Medications

- [Medication Name] - [Dosage] - [Frequency]
- [Medication Name] - [Dosage] - [Frequency]

Recent Tests and Results

[Include any relevant test results and their interpretations]

Next Steps

[Outline any immediate actions required or follow-up plans]

Additional Information

[Any other pertinent information that may assist the specialist]

Attachments

[List of any attached documents, such as lab results or imaging studies]

Thank you for your attention to this referral.

Sincerely,

[Primary Care Provider's Signature]

[Primary Care Provider's Name]

[Title]