

Patient Transfer Request

From:

[Your Name]
[Your Title/Position]
[Your Facility Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Email Address]

Date: [Date]

To:

[Specialist's Name]
[Specialist's Facility Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

Dear [Specialist's Name],

We are writing to request the transfer of the following patient to your facility for specialized care:

Patient Information:

Name: [Patient's Name]
Date of Birth: [Patient's DOB]
Medical Record Number: [Patient's MRN]
Reason for Transfer: [Brief Description of the Reason]

We believe that your expertise in [Specialist's Field] will greatly benefit the patient's treatment. We have attached all relevant medical records and test results for your review.

Please let us know if you require any additional information or if there are specific protocols to follow for the transfer.

Thank you for your assistance in providing the best possible care for our mutual patient.

Sincerely,

[Your Signature (if sending hard copy)]
[Your Printed Name]

[Your Title]
[Your Facility Name]