

UL ^{OF} Physicians

Date:

Dear _____,

_____ is a _____ year old patient under the care of our pediatric sickle cell clinic. He/She will be transferring to your care on/@ _____ of this year. _____'s

primary chronic condition is _____, and his/her secondary conditions are

_____. _____'s related medications and specialists are outlined in the enclosed transfer package that includes his/her medical summary and emergency care plan, plan of care, and transition readiness assessment. _____

acts as his/her own guardian, and is insured under _____ until the age of _____.

I have had _____ as a patient since _____ when he/she was _____ years old. I would be happy to provide any consultation assistance to you during the initial phases of _____'s

transition to your practice. Please don't hesitate to contact me or our transition coordinator, _____, by phone or email if you have any questions. Our contact information is listed below.

Thank you so much for all that you do and your willingness to assume care of _____.

Sincerely,

Doctor's Name:

Phone:

Email: _____@louisville.edu

Transition Coordinator: _____

Phone: _____

Email: _____

Source: www.GotTransition.org