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| FAX |
| **TRANSITION of Care – PROVIDER NOTIFICATION** |

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| Date: |  |  |  |
| To: |  | From: | **, CC/CM** |
| COMPANY: |  | COMPANY: |  |
| Fax: |  | Fax: |  |
| Phone: |  | Phone: |  |
| Subject: | **Transition of Care Notification** | | |

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MESSAGE:

As your patient’s care coordinator, **I was notified** on       that

Patient Name**:** DOB:

was **hospitalized/admitted** at  on

was **admitted to this SNF** on

was **seen** **for an outpatient procedure** at  on

was **discharged/returned to their usual care setting/home** on

As your patient’s care coordinator. I will be assisting the patient during the transition of care process with activities such as:

* Providing follow-up support and coordinating needed services or equipment
* Facilitating communication between the patient, family, and the provider about changes to the plan of care
* Arranging transportation to medical appointments

Please contact me with any questions about this patient’s care transition.

Thank you.

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| **Comments:** |