Transfer-of-Care Summary Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A transfer-of-care summary is the document a therapist, psychologist, counselor, or care coordinator writes when ongoing care moves to a new provider who assumes the client: current status, active risks, medications and supports, and pending items for the receiving clinician. Most run 150 to 600 words, shorter than a discharge summary.

Header: client and both providers responsibility must visibly pass
Do: client identifiers, both clinicians with credentials, practice, and contact, and the acceptance date.
Pitfall: an unnamed receiving provider; "referred to community resources" is an ending, not a transfer.

Reason for transfer and current status today's picture, not the history
Do: why care is moving and the picture as of the summary date: concerns, functioning, latest measure scores.
Pitfall: re-telling the whole treatment history; today's picture is the job, the release covers the rest.

Diagnoses and treatment response what only you can supply
Do: the current diagnosis or problem list, the approach used, and the response: what worked and what did not.
Pitfall: a bare code list; without response information the new clinician repeats experiments the client already sat through.

Medications, allergies, and supports attribute the list
Do: current medications with prescriber named and an as-of date, allergies, and supports: psychiatry, groups.
Pitfall: an unattributed list; if you do not prescribe, say whose list it is and how current it is.

Active risks and safety plan the document's reason to exist
Do: state risk either way, relevant history, and the safety plan's status and next review date if one exists.
Pitfall: silence when risk is low; "no current ideation, low risk" is a finding, an empty section is a gap.

Pending items no owner, nothing happens
Do: everything half-done: reviews due, re-assessments, authorizations, callbacks; owner and date on each.
Pitfall: pending items with no owner; an item nobody owns after the handoff is an item nobody does.

Recommendations, first appointment, and consent make the disclosure defensible
Do: what to do first, a first-appointment window, and the release's date and scope authorizing this disclosure.
Pitfall: sending the summary before the release is signed; the consent status belongs inside the document.

Before you sign

- [ ] Both clinicians named with practices; acceptance date confirmed
- [ ] Risk stated either way, even when low
- [ ] Safety-plan status and next review date included
- [ ] Medication list attributed: prescriber and as-of date
- [ ] Pending items each carry an owner and a date
- [ ] Release date and scope named; original record stays with you

Drafting with AI

Bring the recent notes, the treatment plan, the prescriber's medication list, and the safety plan, however they exist.

> *"Draft a transfer-of-care summary from these notes: client relocating, GAD-7 14 to 8, sertraline per the PCP list of 07/28, safety-plan review due 09/09 passes to the new therapist, first appointment within four weeks: …"*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

150 to 600 words	15 to 30 min by hand	Once per transfer	New clinician · boards
shorter than a discharge summary	clinical team estimate	when a named clinician assumes care	who reads and relies on it

Full guide, sample summary, and compliance notes:
bastiongpt.com/template/transfer-of-care-summary

Transfer-of-Care Summary Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): DOB: Date prepared:

From (sending clinician / credentials / practice / contact):

To (receiving clinician / practice / contact): Acceptance date:

Reason for transfer and current status

Why care is moving · picture as of the date above · most recent measure scores

Diagnoses and treatment response

Current diagnosis or problem list · approach used · what worked and what did not

Medications, allergies, and supports

Current list, prescriber named, as-of date · allergies · psychiatry, groups, case management

Active risks and safety plan

Risk status stated either way · relevant history · safety-plan status and next review date

Pending items

Each with an owner after transfer and a due date: reviews due, re-assessments, authorizations, callbacks

Recommendations, first appointment, and consent

What to do first · suggested window for the first appointment · original record retained by the sender

Release signed: ☐ Date: _____ Scope: _____

Clinician signature / credentials: Date signed: