

NEW JERSEY UNIVERSAL TRANSFER FORM

(Items 1 – 29 must be completed)

1. TRANSFER FROM: _____
 TRANSFER TO: _____

2. DATE OF TRANSFER: _____
 TIME OF TRANSFER: _____ AM PM

3. PATIENT NAME: _____
Last First Name and Nickname MI

4. LANGUAGE: English Other: _____

PATIENT DOB (mm/dd/yyyy): _____ GENDER M F

5. PHYSICIAN NAME _____ PHONE _____

6. CODE STATUS: DNR DNH DNI
 Out of Hospital DNR Attached

7. CONTACT PERSON _____ RELATIONSHIP _____
 PHONE (Day) _____ (Night) _____ (Cell) _____
 NAME OF HEALTH CARE REPRESENTATIVE/PROXY
 OR LEGAL GUARDIAN, IF NOT CONTACT PERSON: _____
 PHONE (Day) _____ (Night) _____ (Cell) _____

8. REASONS FOR TRANSFER: (Must include brief medical history and recent changes in physical function or cognition.) _____

V/S: BP _____ P _____ R _____ T _____ PAIN: None Yes, Rating _____ Site _____ Treatment _____

9. PRIMARY DIAGNOSIS _____ Pacemaker
 Secondary Diagnosis _____ Internal Defib.
 Mental Health Diagnosis (if applicable) _____

10. RESTRAINTS: No Yes (describe) _____

11. RESPIRATORY NEEDS: None Oxygen-Device _____ Flow Rate _____
 CPAP BPAP Trach Vent Related details attached Other _____

12. ISOLATION/PRECAUTION: None MRSA VRE ESBL C-Diff Other _____
 Site _____ Comments _____ Colonized

13. ALLERGIES: None Yes, List _____

14. SENSORY: Vision Good Poor Blind Glasses
 Hearing Good Poor Deaf Hearing Aid Left Right
 Speech Clear Difficult Aphasia

15. SKIN CONDITION: No Wounds
 YES, Pressure, Surgical, Vascular, Diabetic, Other See Attached TAR
 Type: P S V D O
 Site _____ Size _____ Stage (Pressure) _____ Comment _____
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 Site _____ Size _____ Stage (Pressure) _____ Comment _____

16. DIET: Regular Special (describe): _____
 Tube feed Mechanically altered diet Thicken liquids

17. IV ACCESS: None PICC Saline lock IVAD AV Shunt Other: _____

18. PERSONAL ITEMS SENT WITH PATIENT: None Glasses Walker Cane
 Hearing Aid: Left Right Dentures: Upper/Partial Lower/Partial Other: _____

19. ATTACHED DOCUMENTS: MUST ATTACH CURRENT MEDICATION INFORMATION Face Sheet MAR Medication Reconciliation TAR POS Diagnostic Studies
 Labs Operative Report Respiratory Care Advance Directive Code Status Discharge Summary PT Note OT Note ST Note HX/PE
 Other: _____

20. AT RISK ALERTS: None
 Falls Pressure Ulcer Aspiration
 Wanders Elopement Seizure
 Harm to: N/A Self Others
 Weight Bearing Status: None
 Left Leg: Limited Full
 Right Leg: Limited Full

21. MENTAL STATUS: Alert Forgetful Oriented
 Unresponsive Disoriented Depressed
 Other _____

22. PASRR LEVEL I COMPLETED

23. FUNCTION:

	Self	With Help	Not Able
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. IMMUNIZATIONS/SCREENING:
 Flu Date: _____ Tetanus Date: _____
 Pneumo Date: _____ PPD +/- Date: _____
 Other: _____ Date: _____

25. BOWEL: Continent Incontinent Date last BM _____
 Comments: _____

26. BLADDER: Continent Incontinent Foley Catheter
 Comments: _____

27. SENDING FACILITY CONTACT: _____ Title _____ Unit _____ Phone _____
 REC'G FACILITY CONTACT (if known): _____ Title _____ Unit _____ Phone _____

28. FORM PREFILLED BY (if applicable): _____ Title _____ Unit _____ Phone _____

29. FORM COMPLETED BY: _____ Title _____ Unit _____ Phone _____