NEW JERSEY UNIVERSAL TRANSFER FORM

(Items 1 – 28 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) ______

Check if Contact Person:
☐ Health Care Representative/Proxy ☐ Legal Guardian

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 ______
Type: ☐P ☐S ☐V ☐D ☐O
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: ______

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. FUNCTION:

	Self	With Help	Not Able
Walk	☐	☐	☐
Transfer	☐	☐	☐
Toilet	☐	☐	☐
Feed	☐	☐	☐

23. IMMUNIZATIONS/SCREENING:
☐Flu Date: ______ ☐Tetanus Date: ______
☐Pneumo Date: ______ ☐PPD +/- Date: ______
☐Other: ______ Date: ______

24. BOWEL: ☐Continent ☐Incontinent Date last BM ______
Comments: ______

25. BLADDER: ☐Continent ☐Incontinent ☐Foley Catheter
Comments: ______

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: ______

26. SENDING FACILITY CONTACT: ______ Title ______ Unit ______ Phone ______
REC'G FACILITY CONTACT (if known): ______ Title ______ Unit ______ Phone ______

27. FORM PREFILLED BY (if applicable): ______ Title ______ Unit ______ Phone ______

28. FORM COMPLETED BY: ______ Title ______ Phone ______