

# 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 \_\_\_\_\_  
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: \_\_\_\_\_

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     
Transfer     
Toilet     
Feed

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 \_\_\_\_\_