State of New Jersey
Psychiatric Transfer Form - Inpatient Interfacility Transfer
Before Completing Refer to Instructions for Completing Psychiatric Transfer Forms

Name of Patient _____
Date of Birth_____
Social Security Number _____

Part A (completed by Psychiatrist or APN):

1. Describe reason for admission: _____
_____
_____

2. Clinical course as inpatient:_____
_____
_____
_____

3. Justification for Transfer to Next Level of Care: _____
_____
_____

4. Advance Directive for Mental Health Care ☐ No ☐ Yes where available: _____
Healthcare/ End of Life Advance Directive ☐ No ☐ Yes where available: _____

5. Past psychiatric history (Outpatient/ Inpatient) ☐ No ☐ Yes
If yes, give hospital(s) name/location:_____
Describe History:_____
_____
_____

6**.** Substance use
Use in ≤ 30 days ☐ No ☐ Yes If yes, last use date, substance and amount _____
_____

If yes, acute withdrawal symptoms displayed ☐ No ☐ Yes

Methadone maintenance ☐ No ☐ Yes Buprenorphine treatment ☐ No ☐ Yes
If either yes, current dose and date last administered
_____

Name and phone of physician/addictions clinic _____

7. Safety Concerns: ☐ No ☐ Yes

If Yes: ☐ Assaultive/aggressive Behavior ☐ Self Injurious Behavior ☐ Escape Risk ☐ Recent Foreign Body Ingestion

☐ Other:_____

8. History of sexually problematic behavior ☐ No ☐ Yes

If yes, describe _____

9. Legal history (Current or Past): ☐ No/not known ☐ Yes If Yes, check below:

☐ Restraining Order ☐ Active Warrants / Detainer ☐ Court Date Pending

☐ Probation / Parole ☐ Registered Sex Offender (Megan's)

☐ Completed Jail / Prison Term ☐ NGRI / KROL

Charges: _____

10. Diagnosis

Describe diagnostic evaluation (Any psychological testing, MMSE, etc.)

_____

DSM-IV-TR Diagnoses:

- ☐ Axis I _____
- ☐ Axis II _____
- ☐ Axis III _____
- ☐ Axis IV _____
- ☐ Axis V _____

Part B. (completed by Physician and/or Nurse)

In an effort to assist our affiliated agencies with the medical clearance and admission referral process, please attach following documents

- ☐ New Jersey Universal Transfer Form
- ☐ Psychiatric Assessment
- ☐ Psychosocial Assessment
- ☐ History and Physical
- ☐ Medication Administration Records
- ☐ Progress Notes
- ☐ Copy of Original Commitment Papers
- ☐ Psychiatric Advance Directive(If available)
- ☐ Face Sheet
- ☐ Diagnostic Reports

☐ Comprehensive Metabolic Panel (CMP) ☐ TSH ☐ CBC ☐ Serum-HCG

☐ Urine Drug Screen, If Indicated ☐ Relevant Cardiac Studies

☐ Chest X Ray (If Applicable) ☐ VPA

☐ Other Relevant Radiological Studies ☐ Lithium

☐ Consults ☐ Tegretol

☐ EKG ☐ Urine Analysis

☐ Pregnancy Test (If applicable) ☐ No ☐ Yes Results _____ Date _____

☐ Recommended Follow up Care: ☐ Orthopedic ☐ Surgical ☐ Medical Subspecialty ☐ Dialysis

Name and phone of treating physician/clinic

_____

_____

_____

Follow-up in _____Weeks

Additional Notes

_____

_____

_____

Transferring Physician _____ Phone_____

Receiving Physician _____ Phone_____