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** _____

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

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: _____
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: _____
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: _____
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 _____ Phone _____