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*
   PATIENT DOB *(mm/dd/yyyy)*: _____ GENDER ☐M ☐F
4. LANGUAGE: ☐ English ☐ Other: _____
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 _____