NEW JERSEY UNIVERSAL TRANSFER FORM

(Items 1-29 must be completed)

1. **TRANSFER FROM:** ______________________
2. **DATE OF TRANSFER:** ______________________

TRANSFER TO: ______________________

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, <u>P</u>ressure, <u>S</u>urgical, <u>V</u>ascular, <u>D</u>iabetic, <u>O</u>ther** ☐*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 ______________

INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIVERSAL TRANSFER FORM

The purpose of the New Jersey Universal Transfer Form: *A form that communicates pertinent, accurate clinical patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under federal regulations and conveys specific facts that the physician and nurse need to begin caring for a patient. The word patient is used throughout the form, but refers to resident/client or the terminology used by a specific facility or program.*

COMPLETE ALL BOXES #1 - 29

BOX#

1. TRANSFER FROM: Enter the name of the transferring facility or program.
TRANSFER TO: Enter the name of the receiving facility or program.

2. DATE OF TRANSFER: Enter the month, day and year of the transfer.
TIME OF TRANSFER: Enter the time of the transfer, hour, minute, and check-off AM or PM.

3. PATIENT NAME: Enter patient's last name, first name, nickname, and middle initial.
PATIENT DOB: Enter patient's date of birth (month, day, and year).
GENDER: Check appropriate box.

4. LANGUAGE: Check-off or enter patient's primary language.

5. PHYSICIAN: Enter the patient's physician's full name and phone number.

6. CODE STATUS: Check-off the patient's code status, if any.
- **DNR:** Stands for Do Not Resuscitate and is a specific physician's order.
- **DNH:** Stands for Do Not Hospitalize and is a specific physician's order.
- **DNI:** Stands for Do Not Intubate and is a specific physician's order.
- **Out of Hospital DNR Attached:** Attach the patient's legal decision document, "Out-of-Hospital Do Not Resuscitate Order."

7. CONTACT PERSON (Family/Other): Enter the name of the contact person and their relationship to the patient. Enter their daytime, night and cell phone numbers. Check the appropriate box if the contact person is either the patient's health care representative, proxy or legal guardian. If the patient has a Health Care Representative/Proxy or Legal Guardian who is not the contact person, check the appropriate box and enter the name and phone number.

8. REASONS FOR TRANSFER Must include a brief medical history and recent changes in the patient's physical function or cognition. Enter the reason(s) why the patient is being transferred. Include pertinent medical history.
- **V/S:** Stands for vital signs. Enter current vital sign information in spaces provided for BP (Blood Pressure), P (Pulse), R (Respiration), T (Temperature).
- Complete the **PAIN** section. If no pain, check-off "none." If pain, check "yes", enter appropriate number from rating scale (0-10) pain site and current treatment plan.

9. DIAGNOSES: Enter the patient's primary and secondary diagnosis, and treatment. Current mental health diagnosis shall be included, if applicable. Note the relationship, if any, between these diagnoses and the reason for transfer. If the patient has a pacemaker and/or an internal defibrillator, check-off the appropriate box(es).

10. RESTRAINTS: Check the appropriate box to indicate whether the patient is physically restrained (i.e., any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.) Enter type of restraint used. If restraints are used, include reason for restraint in 8.

11. RESPIRATORY NEEDS: If none, check-off "none." Check-off and fill-in requested information as appropriate. If oxygen is being used, include the type of device and flow rate, if any.
- **CPAP:** Stands for constant, positive airway pressure.
- **BPAP:** Stands for bilevel positive airway pressure.
- **Trach:** Stands for tracheotomy tubes.
- **Vent:** Stands for ventilator.
- **Attach related details and/or other:** Means to indicate appropriate descriptions of current patient respiratory status details and needs.

12. ISOLATION / PRECAUTION: If none, check-off "none." Check-off and fill-in requested information.
- **MRSA:** Methicillin-resistant *Staphylococcus aureus* (MRSA).
- **VRE:** Vancomycin-resistant enterococcus (VRE).
- **ESBL:** Beta-lactamases are enzymes produced by some bacteria.
- **C-Diff.:** *Clostridium difficile,* also known as "CDF/cdf" or "C. diff".
- **Other:** List other isolation and/or precautions, their site and comments pertinent to the patients health and care.
- **Colonized:** Check-off "colonized" if the isolation and/or precaution is pathogenic (illness- or disease causing) organisms that are present in a person but are not causing symptoms or clinical findings.

13. ALLERGIES: If none, check-off "none." If allergies, list allergens and reactions. Allergens may include medications, foods, inhalants, environmental substances, latex and other.

INSTRUCTIONS FOR COMPLETING THE NEW JERSEY UNIFORM TRANSFER FORM

(Continued)

14. SENSORY: Check-off appropriate descriptors of the patient's current sight, hearing and speech. More than one box may be checked.

15. SKIN CONDITION: If none, check-off "no wounds." If wounds are present, indicate site and size, circle type. For pressure ulcers also indicate stage and comments. Check-off "see attached TAR", if information regarding the patient's current skin treatment record is attached.

16. DIET: If the patient is not on a special diet, check "regular." If the patient has a special diet, provide a short description. If applicable, check-off "tube feed" and/or "mechanically altered or thicken liquids."

17. IV ACCESS: If none, check-off "none." If IV access, check-off applicable items.

- **PICC:** Stands for peripherally inserted central catheter.
- **Saline Lock:** Is an intravenous connection run intermittently.
- **IVAD:** Implanted Vascular Access Device (IVAD, Vascular Port, Portacath).
- **AV Shunt:** Is an arteriovenous permanent access for hemodialysis.
- **Other:** Means to indicate appropriate descriptions of other current patient IV Access status details and needs (e.g., central line, portacath).

18. Check off personal items sent with patient.

19. Attached Documents:

a. Face Sheet- Sending facility face sheet
b. MAR– Medication Administration Record
c. Medication Reconciliation- if applicable
d. TAR- Treatment Administration Record
e. POS- Physician Order sheet
f. Diagnostic Studies- Recent reports that are applicable to reason for transfer.
g. Labs- Recent lab results that are applicable to reason for transfer.
h. Operative Report- Recent Surgical Report, if applicable to reason for transfer.
i. Respiratory Care- Respiratory therapist notes, if applicable to reason for transfer.
j. Advance Directive– means a written document executed by the patient that includes a proxy directive or an instruction directive or both.
k. Code Status- Attach DNR, DNH if applicable
l. Discharge Summary- Summation of the patient's recent care at the sending facility.
m. PT Note- Physical Therapy notes, if applicable.
n. OT Note- Occupational Therapist note, if applicable.
o. ST Note- Speech Therapist note, if applicable.
p. HX/PE- Physician History and Physical Exam, if applicable
q. Other- Any other necessary document (e.g., consultant report, immunization records).

20. AT RISK ALERTS: Check off known risks. If none, check-off "none." Examples of "other" may include shunt sites and compromised limbs.

- **Weightbearing status:** Check none if patient is completely non-weightbearing. If patient has limited use of one or both legs, check appropriate box(es). If patient is fully weight bearing in one or both legs, check appropriate box(es).

21. MENTAL STATUS (Mental and cognitive assessment): Check-off appropriate descriptors of **normal** mental status. If **current** mental status is pertinent to the primary reason for transfer, indicate changes in box 8.

22. Check off box if PASRR Level I (Preadmission Screening and Resident Review) has been completed.

23. FUNCTION: Check-off appropriate descriptors of the patient's **current** physical functioning. Self means independent, With Help means assistance, Not Able means totally dependent.

24. IMMUNIZATIONS/SCREENINGS: Check off appropriate descriptors of current immunizations and insert the date of immunization.

- **Immunization, FLU:** Influenza vaccine.
- **Immunization, PNEUMO:** Pneumococcal vaccine.
- **Immunization, TETANUS:** Tetanus vaccine.
- **Immunization, PPD:** Test for Tuberculosis (circle results positive +, negative -).
- **Other:** Insert other current immunizations and the date administered.

25. BOWEL: Indicate current function.

26. BLADDER: Indicate current function.

- **Comments:** Identify type of incontinence product used.

27. Sending Facility Contact: is the facility designated individual to sign the Transfer Form.

Receiving Facility Contact: is the individual the facility had phone contact with prior to the transfer, if known.

28. Form Prefilled By: If applicable, facility has sections of form filled out prior to transfer by signee.

29. Form Completed By: Individual completing form at time of transfer in sending facility signs and lists title and phone number.