**Universal Patient Transfer Form**

**Q. What is the Universal Patient Transfer Form?**
A. It is a form that all licensed NJ health care facilities are required to use beginning on October 30, 2011. The purpose of the Universal Transfer Form is to communicate pertinent, accurate clinical patient care information at the time of an emergency call to a facility or a patient transfer between health care facilities or programs. Examples of health care facilities and programs can include hospitals, nursing homes, assisted living facilities, dialysis centers, ambulatory surgical centers or a 911 call from a home health staff member at a patient’s home.

**Q. What will be documented on the Universal Transfer Form?**
A. The form will document patient demographics, sending facility name, receiving facility name, vital signs, diagnosis, primary care physician, medications, allergies, respiratory needs, and cardiac arrest resuscitation status (DNR).

**Q. Does the Universal Patient Transfer Form replace a DNR?**
A. NO. The form will acknowledge if a DNR exists, but proper documentation of a DNR will still need to be supplied to EMS.

**Q. What is the responsibility of EMS to obtain the form?**
A. Upon arrival at a health care facility EMS is to request the form along with all other pertinent medical forms. It is not the responsibility of EMS personnel to complete this form.

**Q. What happens if the form is not available?**
A. EMS is to provide treatment and transportation to the hospital without delay. Upon arrival at the hospital, EMS is to notify the receiving RN that the form was not available, and it will be the responsibility of the receiving facility to contact the transferring facility to obtain the form. The absence of the Universal Transfer Form should be noted on the EMS patient care report.

**Q. Does this form replace the EMS Patient Care Report or EMS Consent for Transport?**
A. NO. Agencies will still be required to complete their EMS Patient Care Report along with the Consent for Transport.

**Q. Is EMS required to keep a copy of this form?**
A. NO. EMS is responsible for handing form to the receiving facility and documenting transfer of form.

**Q. Is EMS required to document their vital signs or anything else on this form?**
A. NO. All EMS documentation should be handled in the EMS Patient Care Report. No documentation is required by EMS on the Universal Patient Transfer Form.
NEW JERSEY UNIVERSAL TRANSFER FORM
(Items 1 – 29 must be completed)

1. TRANSFER FROM: ____________________________
   TRANSFER TO: ____________________________

3. PATIENT NAME: ____________________________
   Last Name and Nickname MI
   PATIENT DOB (mm/dd/yyyy): ________________
   GENDER □M □F

5. PHYSICIAN NAME __________________________
   PHONE ____________________________

7. CONTACT PERSON __________________________
   RELATIONSHIP __________________________
   PHONE (Day) ____________________________
   (Night) ____________________________
   NAMEOF
   OR
   PHONE (Day) ____________________________
   (Night) ____________________________
   HEALTHCARE REPRESENTATIVE/PROXY
   OR
   LEGAL GUARDIAN, IF NOT CONTACT PERSON:
   PHONE (Day) ____________________________
   (Night) ____________________________

8. REASONS FOR TRANSFER: __________________________
   (Must include brief medical history and recent changes in physical function or cognition.)

10. RESTRAINTS: □No □Yes (describe)

11. RESPIRATORY NEEDS: □None □Oxygen-Device □CPAP □BPAP □Trach □Vent □Related details attached □Other

12. ISOLATION/PRECAUTION: □None □MRSA □VRE □ESBL □C-Diff □Other
   Site __________________________
   Comments __________________________

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 □See Attached TAR
   YES, Pressure, Surgical, Vascular, Diabetic, Other

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
   □Out of Hospital DNR Attached
   □Health Care Representative/Proxy □Legal Guardian

23. FUNCTION: Self □Walk □Transfer □Toilet □Feeding
   With Help □Full □Full
   Not Able □Limited □Limited
   □Alert □Forgetful □Oriented
   □Unresponsive □Disoriented □Depressed
   □Other

24. IMMUNIZATIONS/SCREENING:
   □Flu Date: ________________
   □Pneumo Date: ________________
   □Tetanus Date: ________________
   □PPD +/- Date: ________________
   □Other: __________________________

25. BOWEL: □Continent □Incontinent Date last BM __________________________
   Comments: __________________________

26. BLADDER: □Continent □Incontinent □Foley Catheter
   Comments: __________________________

27. SENDING FACILITY CONTACT: __________________________
   Title __________________________
   Unit __________________________
   Phone __________________________

28. FORM PREFILLED BY (if applicable): __________________________
   Title __________________________
   Unit __________________________
   Phone __________________________

29. FORM COMPLETED BY: __________________________
   Title __________________________
   Phone __________________________

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