

The purpose of the New Jersey Transfer Form: A communication form that furnishes accurate clinical communication of pertinent patient care information at the time of a transfer between health care facilities/programs. It conveys the patient information required under Medicare and conveys the many specific facts that the physician and nurse need from the moment a patient becomes their responsibility. It assists them in understanding the patient and in planning the patient's continued course of care. The word patient is used throughout the form, but refers to resident/client or the terminology used by facility.

To accomplish this goal, this form was designed, tested and refined over a three-year period by a task force comprised of nurses, physicians, emergency medical services personnel, the New Jersey Department of Health and Senior Services, the Health Care Association of New Jersey, the New Jersey Hospital Association, the New Jersey Association of Homes and Services for the Aging, the Home Care Association of New Jersey, Rutgers University and others concerned with continuity of care.

INSTRUCTIONS FOR COMPLETING THE FORM:

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 and minute, and check-off AM or PM.
3. **PATIENT NAME:** Enter patient's last name, first name, middle initial, date of birth (month, day, and year).
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.
 - **DNI:** Stands for Do Not Intubate and is a specific physician's order.

- **Out of Hospital DNR attached:** Attach the patient's legal decision making document, "Out-of-Hospital Do Not Resuscitate Order".
7. **CONTACT PERSON (Family/Other):** Check-off the patient's type of health care representative; enter their name and relationship and day/night phone number where they can be reached.
- **HCR:** Stands for Health Care Representative/Proxy and is the individual designated by the patient pursuant to the proxy directive part of an advanced directive for the purpose of making health decisions.
 - **Legal Guardian:** individual appointed by the court to make decisions on the patient's behalf.
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. **DIAGNOSIS:** Must include current mental health, if applicable. Enter the patient's primary and secondary diagnosis, and treatment. Include current mental health, 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(s).
10. **AT RISK ALERTS:** Check off known risks. If none, check-off "none."

Examples of "other" may include shunt sites and compromised limbs.

Has patient/resident been assessed for any of the following risk factors?

- Falls:
- Pressure ulcers:
- Aspiration:
- Wanders :

- **Elopement:**
- **Seizure:**
- **Limited/non-weight bearing:** Person has limited ability to stand or is unable to bear weight on either or both legs.

11. RESTRAINTS: Any manual method or physical or mechanical device,

material or equipment attached or adjacent to the resident's body that the

individual cannot remove easily which restricts freedom of movement or

normal access to one's body that is currently in use for this patient.

12. RESPIRATORY NEEDS: If none, check-off "none." Check-off and fill-in requested information as appropriate. Include the type of device and flow rate, if any. Include type, size and date last changed for tracheotomy tubes, if any. Enter ventilator settings as appropriate.

- **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.

13. ISOLATION / PRECAUTION: If none, check-off "none." Check-off and fill-in requested information.

- **MRSA:** Methicillin-resistant Staphylococcus aureus
- **VRE:** Vancomycin-resistant enterococcus
- **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 patient's health and care.
 - **Colonized:** check-off "colonized" if the isolation and/or precaution is because pathogenic (illness- or disease-

causing) organisms are present in a person but are not causing symptoms or clinical findings.

14. **ALLERGIES:** If none, check-off “none.” If allergies, list allergens and reactions. Allergens may include medications, foods, inhalants, environmental substances, latex and other.
15. **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.
16. **SENSORY:** Check-off appropriate descriptors of the patient’s current sight, hearing and speech. More than one box can be checked.
17. **FUNCTION:** Check-off appropriate descriptors of the patient’s current status in physical functioning. Self means Independent, Help means Assistance, Not able means Totally Dependent.
18. **SKIN CONDITION:** If none, check-off “no wounds.” If wounds are present, indicate site, circle type, indicate size, for pressure ulcers also indicate stage and comments. Check-off “see attached”, if information regarding the patient’s current skin condition is being attached.
19. **DIET:** If the patient is not on a special diet, write “none” in the area next to the word “Special.” If the patient has a special diet, provide a short description. If applicable, check-off “tube feed” and/or “mechanically altered or thicken liquids ” and provide information regarding their diet in the “comments” area.
20. **IV ACCESS:** If none, check-off “none.” If IV access, check-off applicable items.
 - **PICC:** Stands for peripherally inserted central catheter.
 - **Saline Lock:** an intravenous connection which is run intermittently.
 - **IVAD:** Implanted Vascular Access Device, (IVAD, Vascular Port, Portacath)
 - **AV Shunt:** Arteriovenous permanent access for Hemodialysis.

- **Other:** Means to indicate appropriate descriptions of other current patient IV Access status details and needs. (Central Line, portacath)

21. **IMMUNIZATIONS:** 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
- **Other:** Insert other current immunizations and the date administered.

22. **BOWEL:** Indicate what is current function.

23. **BLADDER:** Indicate what is current function.

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

24. **CHECK OFF PERSONAL ITEMS SENT WITH PATIENT.**

25. **ATTACHED DOCUMENTS:**

- Face Sheet:** Sending facility admission sheet
- MAR:** Medication Administration Record
- Medication Reconciliation:** if applicable
- TAR:** Treatment Administration Record
- POS:** Physician Order sheet
- Diagnostic Studies:** Recent reports that are applicable
- Labs:** Recent lab results that are applicable
- Operative Report:** Recent Surgical Report, if applicable
- Respiratory Care:** Respiratory therapist notes, if applicable
- Advance Directive:** means a writing executed by the patient and may include a proxy directive or an instruction directive or both.
- Code Status:** Attach DNR, DNH if applicable
- Discharge Summary:** Summation of the patient's recent care at the facility
- PT Note:** Physical Therapy notes , if applicable
- OT Note:** Occupational Therapist note , if applicable
- ST Note:** Speech Therapist note , if applicable
- HX/PE:** Physician History and Physical Exam , if applicable
- Other:** Any other necessary document

26. **SENDING FACILITY CONTACT:** person designated by the facility to sign the Transfer Form.

RECEIVING FACILITY CONTACT: The person the facility had phone contact with prior to the transfer.

27. **FORM PREFILLED BY:** If applicable, facility has sections of form filled out prior to transfer by signee.

28. **FORM COMPLETED BY:** Individual completing form at time of transfer in sending facility signs and lists the sections they completed.

Rev 05/07/09