Massachusetts Department of Public Health

Instructions for Completion of the Universal Transfer Form

1. This new *Universal Transfer Form* ***takes the place*** of the 3 page patient care referral form or other transfer forms or systems currently in use at your institution.
2. The Transfer Form has the following sections:
    a. **Contact Information & Checklist** (page 1)
    b. **Physician Orders & Nursing Assessment** (pages 2-3)
    c. **Therapy & Behavioral Information** (page 4)
    d. **Medication List** (page 5)
    e. **Tests, Appointments & Additional Notes** (page 6)
    f. **Anticoagulation Referral Form and Warfarin Flow Sheet** (page 7). Note that for many patients, this page will be marked "N/A."

    Depending on the type of patient, additional documentation may be required for a safe and effective transfer (e.g., specific instructions related to high risk OB patients, transplant patients, etc.). Determining which additional documents are needed is left to the discretion of the sending and receiving clinical teams.

3. Unlike some previous forms, the new form does not necessarily have separate pages for each clinician to complete (e.g., page for RN, page for MD, page for SW). While page 2 of the form is primarily designed for physician's orders, clinical teams within each institution must determine who will complete each page of the form. Ultimately the MD/NP/PA ***must*** sign the attestation on page 1, indicating that he/she has reviewed all of the pages for accuracy and completeness. (Note: during off hours in institutions such as nursing homes, rest homes or home health agencies, when an MD/NP/PA may not be available, an RN may complete the form and send with the patient, pending review by the MD during a verbal report with the next set of providers).
4. ***In a true emergency, e.g., when a patient who has become acutely ill is being sent from home health or a skilled nursing facility to the emergency department (ED), there may only be time to complete the essential information on a patient (the checklist on page 1 and page 2); the rest of the packet may be faxed to the ED after EMS has transported the patient for emergency care (within 2 hours).***

Massachusetts Department of Public Health

Contact Information & Checklist

IN CASE OF EMERGENCY PLEASE FILL OUT PAGE 1 & 2 ONLY AND FAX THE REST TO THE EMERGENCY DEPARTMENT AFTER THE TRANSFER HAS TAKEN PLACE

Patient:
Last Name *First Name* *MI*
_____ _____ __ DOB: ___/___/_____

Home Address:_____
Current Address:_____
Phone:_____
Language: English ☐ Other: ☐ _____
Gender M ☐ F ☐

Sent to: *(Name of Facility/Agency/Other)*
_____
Address:
_____
Phone:
( ) _____--_____
Sent from:*(Name of Facility/Agency/Other)*
_____
Date:____/____/_____ Unit:_____

Contact Person (circle one):
(Relative/relationship; guardian or DPOA)
_____*name*
Telephone: ( ) _____-_____
Is this the health care proxy? ☐ Y ☐ N
Notified of transfer: ☐ Y ☐ N

Has the HCP been invoked? ☐ Y ☐ N
HCP if different from Contact Person:
_____*name*
Telephone: ( ) _____-_____
Notified of transfer: ☐ Y ☐ N

Current MD/NP/PA:
☐ **MD** ☐ **NP** ☐ **PA** _____*name*_____*facility*
Telephone:( )_____-_____ Pager:( )_____-_____ Fax:( )_____-_____ Email:_____

Case Manager/Nurse Contact Information:
_____*name* _____*title*
Telephone: *( )* _____-_____
Fax: *( )* _____-_____

PCP or Clinician Assuming Care:
_____*name* _____*title*
Telephone: *( )* _____-_____
Fax: *( )* _____-_____

COPIES/ITEMS SENT WITH PATIENT AT TIME OF TRANSFER:
CM or RN must initial below. Med list, advance directives, must always accompany patient. Med list may be computer generated but must be attached.

____ Current Medication List ____ Last Progress Note ____ Pending Appointments or Laboratory Results

____ Advance Directives ____ Relevant Lab Results & any Labs pending ____ Last H+P

____ Out of hospital DNR or MOLST ____ Hospital or SNF D/C Summary

CONTROLLED SUBSTANCE (NARCOTICS) SENT WITH PATIENT: _____YES _____NO

____ PERSONAL BELONGINGS SENT WITH PATIENT:

____Eyeglasses ____ Hearing Aid ____Dental Appliance ____ Other (specify)_____

Signature of ambulance personnel or family member accepting transfer form: _____
Date: ____/____/_____

Certification: (when applicable) Services are needed to treat condition for which patient was hospitalized ☐ Y ☐ N. I certify that the above named patient is: (check one) ☐ Under my care (or has been referred to another physician having professional knowledge of patient's condition); is home bound except when receiving out-patient services; requires skilled nursing care on an intermittent basis or physical or speech therapy as specified in the orders. ☐ Requires skilled nursing care on a continuing basis for any of the conditions for which he/she received care during this hospitalization.

Attestation: My Signature on this form indicates that I have read all parts of this document and agree with the orders and plans as outlined by the interdisciplinary care team.

Name (Print):_____ Signature:_____ Title:(circle)___MD/NP/PA_____

(Please make a copy and keep this for your records)

Massachusetts Department of Public Health

Universal Transfer Form

Patient Name:_____ Date:_____

Physician Orders & Nursing Assessment

PHYSICIAN ORDERS (MD/NP)

Advance Directive: ☐ **No** ☐ **Yes** **If not addressed why not?**_____

☐ **DNR** ☐ **DNI** ☐ **DNH(Do Not Hospitalize)** ☐ **Full Code** _____

Goals of Care:

Hospice: ☐Yes ☐No

BRIEF SUMMARY *(See D/C Summary for more detail)*

Reason for transfer:
Summary:

Heads Up: *(Clinical Issues Requiring Attention, Special Circumstances or Potential Complications)*

Pregnant: ☐Yes ☐No ☐N/A

Principal Diagnosis at Discharge:_____
Additional Diagnoses:_____
_____

Allergies:_____

VS: BP_____ HR_____ RR_____ T_____ pO2_____ FS blood glucose_____
Pulse OX Range: _____ Current Weight: _____ Time VS Taken: ____:____ AM/PM
Medications: see attached Medication List

PAIN ASSESSMENT
Pain Score:
_____ out of _____
Pain Scoring System used:
_____
Location/s:_____
_____
Pain Medication/s:
_____
_____
Script/s sent: ☐ Y ☐ N
Other treatment modalities:
_____
_____

NURSING ASSESSMENT (RN)

Mental Status at Discharge:
- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, but cannot follow simple instructions
- ☐ Not alert

Functional Status at Discharge:
- ☐ Ambulates independently
- ☐ Ambulates with assistance
- ☐ Ambulates with assistive device
- ☐ Not ambulatory

IMMUNIZATIONS:
Influenza: Date:____/____/_____ Tetanus Booster Date:____/____/_____ Tetanus Tet-Diphtheria Date:____/____/_____
Pneumococcal Date:____/____/_____ Other (H1N1 etc.):_____ Date:____/____/_____

DEVICES/ SPECIAL TREATMENTS:
- ☐ IV/PICC line/Portacath
- ☐ Pacemaker
- ☐ Foley Catheter
- ☐ Internal Defibrillator
- ☐ TPN
- ☐ Other:_____
- ☐ If on anticoagulation, see page 7

AT RISK ALERTS:
- ☐ Pain ☐ Seizure
- ☐ Falls ☐ Pressure Ulcer
- ☐ Restraints
- ☐ Aspiration ☐ Wanderer
- ☐ Limited/non-weight bearing ☐ Left ☐ Right, see page 4
- ☐ Elopement ☐ Other: _____

ISOLATION/ PRECAUTION:
- ☐ MRSA ☐ VRE ☐ C-Diff
- ☐ Other:_____
- Site:_____
- Comment:_____

Massachusetts Department of Public Health

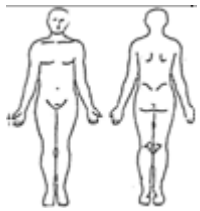
Universal Transfer Form

Patient Name:_____ Date:_____

Patient Assessment: RN/CM/DP may complete this page

TREATMENT ORDERS AND FREQUENCY
(include special treatments such as dialysis, chemo-therapy, transfusions, radiation, TPN, fluid restriction, fingersticks, wt checks and freq., attach detail as needed)

SKIN / WOUND CARE ORDERS
Pressure ulcers:
(stage, location, appearance, treatments)



Other Wounds : ☐ Yes ☐ No
if yes, describe:

Wound care sheet attached: ☐ Yes ☐ No

DIET ORDERS
Needs assistance with feeding: ☐ Yes ☐ No
Trouble swallowing: ☐ Yes ☐ No
Special diet or consistency:*(thicken liquids, crush meds, etc)*
_____
Tube feeding: ☐ Y ☐ N Pump_____ Bolus_____
If yes, type of formula:_____ ml/hr_____
water flush_____ ml/hr_____
Additional Diet Orders: (diabetic, low sodium etc)
_____
_____
_____
_____

INSURANCE INFORMATION
Company:_____
Patient Insurance Number:_____
Provider Phone: ( )_____-_____
Medicare:
Type: ☐ A ☐ B ☐ D ☐ N/A #:_____
Medicaid
☐N/A #:_____

ACTIVITIES OF DAILY LIVING:
(mark I=independent; D=dependent; A=needs assistance)
_____ Bathing _____ Toileting/Transfers
_____ Dressing _____ Ambulation
_____ Eating

Mobility
_____ Can ambulate _____ (distance) with
_____(Assistive Device or Independent)

Upper extremities ☐ Normal ☐ Impaired:_____
Lower extremities ☐ Normal ☐ Impaired:_____

CONTINENCE:

	Bowel	Bladder
Continent	☐	☐
Occasionally Incontinent	☐	☐
Incontinent	☐	☐

Last bowel movement: Date:___/___/____
Catheter last changed: Date:___/___/____
Foley Type/Balloon Size:_____

Vision:
☐ Sees Adequately
☐ Impaired – sees large print but not regular print.
☐ Moderately impaired –
limited vision cannot see headlines.
☐ Severely impaired –
no vision or only sees light, color shapes

☐ Uses Visual Aid
Type:

Auditory:
☐ Hears Adequately
☐ Minimal Difficulty
☐ Intermittently Impaired
☐ Highly Impaired

☐ Uses Auditory Aid
Type:

Communication
Primary Language:_____
Able to: ☐ Understand ☐ Speak ☐ Read ☐Write

Secondary Language:_____
Able to: ☐ Understand ☐ Speak ☐ Read ☐Write

Aphasia: ☐ Expressive ☐Receptive
Sign language use: ☐ Yes ☐ No

Massachusetts Department of Public Health

Universal Transfer Form

Patient Name:_____ Date:_____

Therapy & Behavioral Health Information

RESTRICTED ACTIVITIES and RESUME DATE/ORDERS

Bath	☐ _____	Sexual Activity	☐ _____
Shower	☐ _____	Doing Housework	☐ _____
Lifting	☐ _____	Driving	☐ _____
Walking	☐ _____	Going to Work	☐ _____
Climbing Stairs	☐ _____	Sports	☐ _____

WEIGHT BEARING STATUS

☐ Non-weight ☐ Partial weight ☐ Full weight
__L __R __L __R __L __R

☐ Amputee
☐ Prosthesis use: _____
☐ Equipment needed at time of transfer: _____
_____

PHYSICAL/OCCUPATIONAL/SPEECH THERAPY

Evaluations:
PT: ☐Yes ☐No **OT**: ☐Yes ☐ No **ST**: ☐Yes ☐No
Interventions/Notes:_____
_____
_____
_____
Detail Attached ☐ Yes ☐ No

RESPIRATORY CARE

☐ Nebulizers ☐ O2 _____liters via_____
☐ Tracheostomy
☐ Other:_____
_____

MEDICAL SUPPLY (DME) NEEDS:
Were supplies ordered? ☐ Y ☐ N
If yes, were they sent? ☐ Y ☐ N
FOR MEDICATIONS AT TIME OF DISCHARGE
PLEASE SEE ATTACHED LIST

BEHAVIORAL HEALTH, SOCIAL, or FAMILY ISSUES & INTERVENTIONS

Discharge Teaching Completed: ☐ Y ☐ N Teach Back ☐ Y ☐ N

I have participated in and understand the development of this discharge plan. I have received a copy of the plan.
Patient/Representative Signature_____Date_____
Patient is not able to understand the information and the representative is not available to sign this form ☐
Signature_____(RN/CM/DP) Date_____

Massachusetts Department of Public Health

Universal Transfer Form

Patient Name:_____ DOB:_____ Date:_____ Height:_____ Weight:_____

Medication List

	Prescribed by/Phone	Medication (including trade and generic names)	Reason for medication	Dose/Times taken/How taken (Example: 100 mg three times a day by mouth)	Other Directions or Notes
1	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
2	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
3	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
4	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
5	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
6	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	
7	Prescribed by: _____ ☐ **N/A Over-The-Counter** Phone: ( )_____--_____			Last Taken: am/pm	

Medication Reconciliation completed Yes_____ No____

Massachusetts
Department of
Public
Health

Universal Transfer Form

Patient Name:________________________ Date:_____________

Tests, Appointments & Additional Notes

Tests not due/available until after transfer		**Follow – up Appointment Information**	
Name of Test: Reason for Test:	Date done:______________ Results due by: ___________ Contact:_______________ Phone: ( )_____-_______	Appointment With: Appointment For: Appointment needed by ___________________	Date: _______________ Time:______________ Phone: ( )____-______ Address:_________________ ________________________
Name of Test: Reason for Test:	Date done:______________ Results due by: __________ Contact:_______________ Phone: ( )_____-_______	Appointment With: Appointment For: Appointment needed by ____________________	Date: _______________ Time:______________ Phone: ( )____-______ Address:_________________ ________________________
Name of Test: Reason for Test:	Date done:______________ Results due by: __________ Contact:_______________ Phone: ( )_____-_______	Appointment With: Appointment For: Appointment needed by ____________________	Date: _______________ Time:______________ Phone: ( )____-______ Address:_________________ ________________________
Additional Test Information Attached: ☐ Y ☐ N		Additional Follow-up Information Attached: ☐ Y ☐ N	

Additional Notes:
Discipline:______________ Name:_____________________ Title:_____________ Phone: (   )____-________

Additional Notes:
Discipline:______________ Name:_____________________ Title:_____________ Phone: (   )____-________

Form Completion Signature:

As the RN/CM/DP I have reviewed and completed all necessary information on this form.

Form Completed by: ________________________________ *name* ______________________ *title*
________________________________ *signature* ______________________ *phone*
Report Called in by:________________________________ *name* ______________________ *title*
Report Called to:________________________________ *name* ______________________ *title*

Massachusetts Department of Public Health

Universal Transfer Form

Patient Name:_____ Date:_____

NA ☐

Anticoagulation Orders & Warfarin Flow Sheet

Please check appropriate box **and** provide name and contact number of discharge provider or person you spoke with at follow-up site who has agreed to manage anticoagulation after discharge:

☐ Primary Care Physician _____name _____phone _____fax

☐ Anticoagulation Clinic _____name _____phone _____fax

☐ Facility Provider _____name _____phone _____fax

☐ Other:_____ _____name _____phone _____fax

Warfarin Start Date & End Date	**Initial Warfarin Dose:**	**Indication:**	**INR Goal:**
Pre-admit dose obtainable? ☐ Y ☐ N Pre-admit:_____ _____ Start Date: ____/____/_____ End Date:____/____/____ Duration: □ 2 weeks □ 4 weeks □ 3 months □ 6 months □ Indefinite □ Other: _____ _____	☐ New Start **Dose**:_____ ☐ Home Dose M:_____ T:_____ W:_____ TH:_____ F:_____ Sat:_____ Sun:_____	☐ Atrial fibrillation ☐ Venous Thrombosis (VTE) ☐ VTE prevention ☐ Stroke ☐ Cardiomyopathy ☐ Myocardial infarction ☐ Mitral Valve ☐ Aortic Valve ☐ Other:_____	☐ 2.0 – 2.5 ☐ 2.0 – 3.0 ☐ 2.5 – 3.5 ☐ Other: _____

Next INR: ____/____/____*date* _____*location* Patient Education Provided? ☐ Y ☐ N

Date:	**INR:**	**Dose:**	**Notes:**	**Signature:**