Universal Transfer Form

DNR: ☐Yes ☐No

Reason for Transfer: _____

Clinical Summary:

_____

_____

_____

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
☐Non ambulatory

Numeric Pain Score: ☐1☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **Location**_____

Medications administered today with time:

_____

_____

_____

Isolation/ Precaution: ☐N/A ☐MRS ☐VRE ☐C-Diff ☐Other_____

Communication Interpreter Required ☐Yes ☐No
Primary Language: _____ Able to: ☐Understand ☐Speak ☐Read ☐Write
Secondary Language: _____Able to: ☐Understand ☐Speak ☐Read ☐Write☐ N/A
Aphasia: ☐Expressive ☐Receptive. Sign language use: ☐Yes ☐No

Devices/ Special Treatments:
☐N/A
☐V/PICC line/Portacath
☐Pacemaker
☐Foley Catheter
☐Internal Defibrillator
☐TPN
Other:_____

At Risk Alerts:
☐N/A
☐Pain ☐Seizure
☐Falls ☐Pressure Ulcer
☐Bleeding ☐Aspiration
☐Wanderer ☐Elopement
Limited/non-weight bearing
☐Left ☐Right
☐Other: _____

Equipment Needed: ☐Walker Cane ☐W/C ☐Brace ☐Specialty Mattress ☐Wound VAC ☐N/A

Weight Bearing Status: ☐Non-weight ☐Partial weight ☐Full weight ☐Amputee ☐Prosthesis use ☐N/A
☐ L ☐R ☐L ☐R ☐L ☐R

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

Activities of Daily Living:
(mark I=independent; D=dependent; A=needs assistance)
_____ Bathing
_____ Dressing
_____ Eating
_____ Toileting/Transfers
_____ Ambulation

Continence:

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

Last bowel movement:
Date: MM/DD/YYYY

Catheter last changed:☐N/A
Date: MM/DD/YYYY

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:_____

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Auditory:

☐Hears adequately ☐Uses Auditory Aid
☐Minimal Difficulty Type: _____
☐Intermittently Impaired
☐Highly Impaired

Needs assistance with feeding: ☐Yes ☐No
Trouble swallowing: ☐Yes ☐No

Staff Member that completed this form:
First Name: _____Middle Name: _____Last Name: _____
Name of Facility: _____
Date: MM/DD/YYYY
Patient Demographics
First Name: _____Middle Name: _____Last Name: _____
Gender: ☐F ☐M
Date of Birth: MM/DD/YYYY
Family Member Name: _____
Health Care Provider Name: _____