DNR: ☐ Yes ☐ No

Reason for Transfer: _______________________________________________________________

Clinical Summary: _________________________________________________________________

_________________________ _____________ ______

Mental Status at Discharge:  Functional Status at Discharge:
☐ Alert, oriented, follows instructions  ☐ Ambulates independently
☐ Alert, disoriented, but can follow simple instructions  ☐ Ambulates with assistance
☐ Alert, disoriented, but cannot follow simple instructions  ☐ Ambulates with assistive device
☐ Not alert  ☐ 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:  At Risk Alerts:
☐ N/A  ☐ N/A
☐ V/PICC line/Portacath  ☐ Pain  ☐ Seizure
☐ Pacemaker  ☐ Falls  ☐ Pressure Ulcer
☐ Foley Catheter  ☐ Bleeding  ☐ Aspiration
☐ Internal Defibrillator  ☐ Wanderer  ☐ Elopement
☐ TPN  Limited/non-weight bearing
Other: ____________________  ☐ Left ☐ Right
☐ Non-ambulatory

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  _____________  Toileting/Transfers  _____________
Dressing  _____________  Ambulation  _____________

Continence:  Bowel  Bladder  Vision:
☐ Continent  ☐ Sees Adequately
☐ Occasionally Incontinent  ☐ Impaired – sees large print but not regular print.
☐ Incontinent  ☐ Moderately impaired – limited vision cannot see headlines.
☐ Non-ambulatory  ☐ Severely impaired – no vision or only sees light, color shapes

Last bowel movement:  Catheter last changed: ☐ N/A  ☐ Uses Visual Aid  Type:___________
Date: MM/DD/YYYY  Date: MM/DD/YYYY
Universal Transfer Form

Auditory:
☐ Hears adequately
☐ Uses Auditory Aid
☐ Minimal Difficulty
☐ 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: ___________________________________________