**Universal Transfer Form**

AMDA has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

<table>
<thead>
<tr>
<th>Patient's name:</th>
<th>Patient Identifier #2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting Discharged from:</td>
<td>Setting Discharged to:</td>
</tr>
<tr>
<td>Attending physician in setting discharged from:</td>
<td></td>
</tr>
<tr>
<td>Admission date:</td>
<td>Discharge date:</td>
</tr>
</tbody>
</table>

A. Admitting diagnosis: ___________________________

B. Other diagnoses from this admission:

<table>
<thead>
<tr>
<th>1.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>5.</td>
</tr>
<tr>
<td>3.</td>
<td>6.</td>
</tr>
</tbody>
</table>

C. Current diagnoses prior to admission:

<table>
<thead>
<tr>
<th>1.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>5.</td>
</tr>
<tr>
<td>3.</td>
<td>6.</td>
</tr>
</tbody>
</table>

D. Surgical procedures and endoscopies during admission (include name of physician who performed the procedure) None

<table>
<thead>
<tr>
<th>1.</th>
<th>Date/results</th>
<th>2.</th>
<th>Date/results</th>
<th>3.</th>
<th>Date/results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(may attach)</td>
<td></td>
<td>(may attach)</td>
<td></td>
<td>(may attach)</td>
</tr>
</tbody>
</table>

E. Laboratory values (please record most recent results, with date)

- WBC / / _____
- Hgb / / _____
- Na+ / / _____
- K+ / / _____
- Fasting glucose / / _____
- BUN / / _____
- Creatinine / / _____
- TSH/T4/T3 / / _____
- Other / / _____

F. Results and dates of pertinent studies (radiology, CT, MRI, nuclear scans, etc.) (may attach)

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-ray:</td>
<td>Date performed:_____</td>
<td>Results: No active disease:_____</td>
</tr>
<tr>
<td>Or description if abnormal:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

G. Allergies:

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Reaction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
<td>Reaction:</td>
</tr>
<tr>
<td>Foods:</td>
<td>Reaction:</td>
</tr>
<tr>
<td>Other:</td>
<td>Reaction:</td>
</tr>
</tbody>
</table>
H. Admission weight_____; Discharge weight:_____

I. Advance directives:  
   Yes  No  
   CPR  □  □  
   PEG tube feeding  □  □  
   Further hospitalization  □  □  
   Other: ________________________________  
   (Attach copies)

J. Has patient had a recent fall? Yes □ No □  Is patient at risk for wandering? Yes □ No □

K. Comments on inpatient course: (may attach summary)  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  
   ____________________________________________________________________________  

L. Is the patient aware of his/her diagnosis(es)? Yes □ No □  
   If No, why not? ____________________________________________________________

M. Patient’s cognitive status for decision-making:  
   ___ Independent  _____Modified independence (some difficulty in new situations)  
   ___ Moderately impaired (decisions poor)  ___Severely impaired (never/rarely makes decisions)

N. Is the patient a candidate for rehabilitation therapy? Yes □ No □  
   If yes, state goals for rehabilitation:  
   ____________________________________________________________________________  
   ____________________________________________________________________________

O. Discharge medication orders:  
   1. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   2. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   3. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   4. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   5. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   6. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   7. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   8. ___________________________  Rational: ___________________________  
      Dose _________ Route _________ Frequency _________  
   9. ___________________________  Rational: ___________________________
Dose _________ Route __________ Frequency __________

10. ___________________________________ Rational: ____________________

Dose _________ Route __________ Frequency __________

P. Is patient currently on antibiotics? Yes □ No: □
Reason for antibiotic: ____________________________________________________________
Antibiotic stop date: __________________
Has patient been on antibiotics in last two weeks? Yes □ No: □
Does patient have a history of MDRO? Yes □ No: □
If yes, what type? _____________________________________________________________
Has patient had a history of infectious diarrhea within the last 30 days? Yes □ No: □

Q. Diet: __________________________________________________________________________

R. Immunizations: Influenza: _____ Date PPD: _____ Results _____ Date _____
Pneumococcal: _____ Date TD: _____ Date +/-

S. Additional orders: __________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

T. Follow-up on consults/tests/procedures recommended: __________________________________________________________________
____________________________________________________________________________________

U. Is patient legally competent? Yes □ No: □
If no, name of legally appointed decision-maker:
____________________________________________________________________________
If yes, but has a decision-maker, name of decision-maker:
____________________________________________________________________________

Name of physician /designee completing form: __________________________________________
Contact phone number: ( ) ______-___________ Extension or pager: _________________________
Date form completed: / /

Name of Primary Care Physician
Contact phone number: ( ) ______-___________ Extension or pager: _________________________