



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.

Patient's name: _____ Patient Identifier #2: _____

Setting Discharged from: _____

Setting Discharged to: _____

Attending physician in setting discharged from: _____

Admission date: / /

Discharge date: / /

A. Admitting diagnosis: _____

B. Other diagnoses from this admission:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

C. Current diagnoses prior to admission:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

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

- | | |
|----------|---------------------------------|
| 1. _____ | Date/results _____ (may attach) |
| 2. _____ | Date/results _____ (may attach) |
| 3. _____ | Date/results _____ (may attach) |

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

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

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

1. _____
2. _____
3. _____
- Chest X-ray: Date performed: _____ Results: No active disease: _____
 Or description if abnormal: _____

G. Allergies:

Medication: _____	Reaction: _____
Medication: _____	Reaction: _____
Foods: _____	Reaction: _____
Other: _____	Reaction: _____

H. Admission weight _____;

Discharge weight: _____

I. Advance directives:

	Yes	No
CPR	<input type="checkbox"/>	<input type="checkbox"/>
PEG tube feeding	<input type="checkbox"/>	<input type="checkbox"/>
Further hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
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. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
2. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
3. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
4. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
5. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
6. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
7. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
8. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
9. _____ Rationale: _____
Dose _____ Route _____ Frequency _____
10. _____ Rationale: _____
Dose _____ Route _____ Frequency _____

