

## 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 #: \_\_\_\_\_  
Setting Discharged from: \_\_\_\_\_ Patient's date of birth: \_\_\_\_\_  
Setting Discharged to: \_\_\_\_\_ Patient's gender Male: \_\_\_\_\_ Female: \_\_\_\_\_  
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  Physician name: \_\_\_\_\_  
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+	//	_____	CL	//	_____
K+	//	_____	CO <sub>2</sub>	//	_____
Fasting glucose	//	_____	Other	//	_____

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: \_\_\_\_\_



7. \_\_\_\_\_ Rationale: \_\_\_\_\_  
 Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_
8. \_\_\_\_\_ Rationale: \_\_\_\_\_  
 Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_
9. \_\_\_\_\_ Rationale: \_\_\_\_\_  
 Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_
10. \_\_\_\_\_ Rationale: \_\_\_\_\_  
 Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_
11. \_\_\_\_\_ Rationale: \_\_\_\_\_  
 Dose \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

P. Diet: \_\_\_\_\_

Q. Immunizations: Influenza: \_\_\_ Date: \_\_\_ Pneumococcal: \_\_\_ Date: \_\_\_  
 Tetanus-Diphtheria: \_\_\_ Date: \_\_\_  
 Tests: PPD: \_\_\_ Results: \_\_\_ +/- \_\_\_ Date: \_\_\_

R. Additional orders: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

S. Follow-up on consults/tests/procedures recommended: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

T. Is patient the primary decision maker? Yes \_\_\_ No: \_\_\_  
 If no, name of the substitute or surrogate: \_\_\_\_\_

Name of physician /designee completing form: \_\_\_\_\_  
 Contact phone number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Extension or beeper: \_\_\_\_\_  
 Date form completed: / /

Name of Primary Care Physician  
 Contact phone number: ( ) \_\_\_\_\_ - \_\_\_\_\_ Extension or beeper: \_\_\_\_\_