State of New Jersey Psychiatric Transfer Form - Inpatient Interfacility Transfer *Before Completing Refer to Instructions for Completing Psychiatric Transfer Forms

Name of Patient					
Date of Birth					
Social Security Number					
Part A (completed by Psychiatrist or APN):					
1. Describe reason for admission:					
2. Clinical course as inpatient:					
3. Justification for Transfer to Next Level of Care:					
4. Advance Directive for Mental Health Care □ No □ Yes where available:					
Healthcare/ End of Life Advance Directive No Yes where available:					
5. Past psychiatric history (Outpatient/ Inpatient) □ No □ Yes					
If yes, give hospital(s) name/location:					
Describe History:					
6. Substance use					
Jse in ≤ 30 days □ No □ Yes If yes, last use date, substance and amount					
If yes, acute withdrawal symptoms displayed □ No □ Yes					
7.1.,					
Methadone maintenance ☐ No ☐ Yes Buprenorphine treatment ☐ No ☐ Yes					
If either yes, current dose and date last administered					
Name and phone of physician/addictions clinic					

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7. Safety Concerns: ☐ No ☐ Yes						
If Yes: □ Assaultive/aggressive Behavior □ Self Injurious Behavior □ Escape Risk □ Recent Foreign Body Ingestion						
□ Other:						
8. History of sexually problematic behavior No Yes If yes, describe						
9. Legal history (Current or Past): ☐ No/not known ☐ Yes If Yes, check below:						
☐ Restraining Order ☐ Active Warrants / Detainer ☐ Court Date Pending						
□ Probation / Parole □ Registered Sex Offender (Megan's)						
□ Completed Jail / Prison Term □ NGRI / KROL						
Charges:						
10. Diagnosis						
Describe diagnostic evaluation (Any psychological testing, MMSE, etc.)						
DSM-IV-TR Diagnoses:						
□ Axis I						
□ Axis II						
□ Axis III						
□ Axis IV						
□ Axis V						

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Part B. (completed by Physician and/or Nurse)

In an effort to assist our affiliated agencies with the medical clearance and admission referral proces						
	please attach following documents □ New Jersey Universal Transfer □ Psychiatric Assessment □ Psychosocial Assessment □ History and Physical □ Medication Administration Recount □ Progress Notes □ Copy of Original Commitment I □ Psychiatric Advance Directive(□ Face Sheet □ Diagnostic Reports	r Form ords Papers	3			
	☐ Comprehensive Metabolic Panel (CMP) ☐ TSH	□ CE	BC □ Serum-HCG			
	□ Urine Drug Screen, If Indicated		Relevant Cardiac Studies			
	□ Chest X Ray (If Applicable)		VPA			
	□ Other Relevant Radiological Studies		Lithium			
	□ Consults		Tegretol			
	□ EKG	□ L	Jrine Analysis			
	☐ Pregnancy Test (If applicable) ☐ No ☐ Yes Results		Date			
	□ Recommended Follow up Care: □ Orthopedic □ Name and phone of treating physician/clinic	Surgica	al □ Medical Subspecialty □ D	ialysis		
	Follow-up inWeeks Additional Notes					
Tra	Transferring Physician		Phone			
	Receiving Physician		Phone			