Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer.

Please attach copies of latest culture reports with susceptibilities if available

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number
		/ /	

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Contact Name	Phone	E-mail
Transferring RN/Unit			
Transferring Physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonization or history Check if yes	Active infection on treatment Check if yes
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridioides difficile		
Acinetobacter, multidrug-resistant		
Enterobacteriaceae (e.g., E. coli, Klebsiella, Proteus) producing-Extended Spectrum Beta-Lactamase (ESBL)		
Carbapenem-resistant Enterobacteriasceae (CRE)		
Other, specify (e.g., lice, scabies, norovirus, influenza):		

Does the person* currently have any of the following? (Check here □ if none apply)

□ Cough or requires suctioning
□ Diarrhea
□ Vomiting
□ Incontinent of urine or stool
□ Open wounds or wounds requiring dressing change
□ Drainage (source _____)
□ Central line/PICC (Approx. date inserted ___/___/_____)
□ Hemodialysis catheter
□ Urinary catheter (Approx. date inserted ____/____/_____)
□ Suprapubic catheter
□ Percutaneous gastrostomy tube
□ Tracheostomy

Is the person* currently in Transmission-Based Precautions? □ NO □ YES

Type of Precautions (check all that apply) □ Contact □ Droplet □ Airborne □ Other:_____

Reason for Precautions:_____

Is the person* currently on antibiotics? □ NO □ YES (current use)

Antibiotic, dose, route, freq.	Treatment for:	Start Date	Anticipated Stop Date	Date/time last dose

Vaccine	Date Administered (if known)	Lot and Brand (if known)	Year administered (if exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				□ Yes □ No
Pneumococcal (PPSV23)				□ Yes □ No
Pneumococcal (PCV 13)				□ Yes □ No
Other:				□ Yes □ No

Name of staff completing form (Print)	Signature	Date	If information communicated prior to transfer: Name and phone of individual at receiving facility

***refers to patient or resident depending on transferring facility**