

Inter-facility Infection Control Transfer Form

This form should 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 | NAME | PHONE | E-mail |
|---------------------------|------|-------|--------|
| Case Manager/Admin/SW | | | |
| Infection Prevention | | | |

Is the patient currently in isolation? NO YES
 Type of Isolation (check all that apply) Contact Droplet Airborne EBP
 Other: _____

| Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance? | Colonization or history <i>Check if YES</i> | Active Infection on Treatment <i>Check if YES</i> | Culture Site |
|---|--|--|--------------|
| Methicillin-resistant Staphylococcus aureus (MRSA) | | | |
| Vancomycin-resistant Enterococcus (VRE) | | | |
| Clostridium difficile | | | |
| Carbapenem-resistant Enterobacteriaceae or Organism (CRE/CRO) | | | |
| E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL) | | | |
| Carbapenemase-producing organism (KPC, OXA-48, IMP, NDM, VIM) | | | |
| Other: | | | |

Does the patient/resident currently have any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Cough or requires suctioning | <input type="checkbox"/> Central line/PICC (Approx. date inserted __/__/__) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemodialysis catheter |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary catheter (Approx. date inserted __/__/__) |
| <input type="checkbox"/> Incontinent of urine or stool | <input type="checkbox"/> Suprapubic catheter |
| <input type="checkbox"/> Open wounds or wounds requiring dressing change | <input type="checkbox"/> Percutaneous gastrostomy tube |
| <input type="checkbox"/> Drainage (source) _____ | <input type="checkbox"/> Tracheostomy |

Antibiotic history during current hospitalization or within past 30 days? NO YES

| Antibiotic and dose | Treatment for: | Start Date | Anticipated stop date |
|---------------------|----------------|------------|-----------------------|
| | | | |
| | | | |
| | | | |

| Vaccine | Date administered (If known) | Lot and Brand (If known) | Year administered (If exact date not known) | Does patient self report receiving vaccine? | |
|----------------------|------------------------------|--------------------------|---|---|--------------------------|
| Influenza (seasonal) | | | | <input type="radio"/> yes | <input type="radio"/> no |
| Pneumococcal | | | | <input type="radio"/> yes | <input type="radio"/> no |
| Tdap | | | | <input type="radio"/> yes | <input type="radio"/> no |
| Other: _____ | | | | <input type="radio"/> yes | <input type="radio"/> no |

| Printed Name of Person completing form | Signature | Date | If information communicated prior to transfer: Name and phone of individual at receiving facility |
|--|-----------|------|---|
| | | | |