Inter-Facility Infection Control Transfer Form

SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY

Please attach copies of latest culture reports with susceptibilities, if available.

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medial 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/resident currently on antibiotics? □ NO □ YES DX: _________________________

Does the patient/resident have pending cultures? □ NO □ YES

Is the patient/resident currently on precautions? □ NO □YES

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

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO)?	**Colonization or history** *Check if YES*	**Active infection on Treatment** *Check if YES*
Methicillin-resistant *Staphylococcus aureus* (MRSA)		
Vancomycin-resistant *Enterococcus* (VRE)		
***Clostridium difficile* (C. Diff, CDI)**		
Acinetobacter* spp., multidrug-resistant		
E coli, Klebsiella, Proteus* etc. w/Extended Spectrum B-Lactamase (ESBL)		
Carbapenemase resistant *Enterobacteriaceae* (CRE)*		
Other:		

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

- ☐ 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

Notes:

Printed Name of Person Completing Form	**Signature**	**Date**	**If information communicated prior to transfer: Name and phone of individual at receiving facility**