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	Email
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 Enterobacteriaceae (CRE)	☐	☐
Pseudomonas aeruginosa, multidrug-resistant	☐	☐
Candida auris	☐	☐
Other, specify (e.g., lice, scabies, norovirus, influenza, COVID-19):_____ If COVID-19, please include date of diagnosis: _____	☐	☐

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

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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

Antibiotic, Dose, Route, Frequency	Treatment for	Start Date	Anticipated Stop Date	Date/Time of Last Dose

Has the person* received treatment for COVID-19? ☐ No ☐ Yes
(monoclonal antibody treatment, convalescent plasma, etc.)

Dose, Route, Frequency	Start Date	Anticipated Stop Date	Date/Time of Last Dose

Vaccine	Date Administered (If known)	Lot and Brand (If known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)			☐ Yes ☐ No
Pneumococcal (PPSV23)			☐ Yes ☐ No
Pneumococcal (PCV13)			☐ Yes ☐ No
COVID-19	*REQUIRED* Dose 1: _____ Dose 2: _____ Booster Dose/ Additional Dose: _____	*REQUIRED* ☐ Pfizer-BioNTech ☐ Moderna ☐ Other: _____	☐ Yes ☐ No
Other: _____			☐ Yes ☐ No

**Refers to patient or resident, depending on transferring facility*

Name of staff completing form (print): _____

Signature: _____ Date: _____

If information communicated prior to transfer:

Name of individual at receiving facility: _____ Phone of individual at receiving facility: _____

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