

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)	<input type="checkbox"/>	<input type="checkbox"/>
Vancomycin-resistant Enterococcus (VRE)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Clostridioides difficile</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Acinetobacter</i> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
Enterobacteriaceae (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i>) producing- Extended Spectrum Beta-Lactamase (ESBL)	<input type="checkbox"/>	<input type="checkbox"/>
Carbapenem-resistant Enterobacteriaceae (CRE)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Pseudomonas aeruginosa</i> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
<i>Candida auris</i>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify (e.g., lice, scabies, norovirus, influenza, COVID-19): _____ If COVID-19, please include date of diagnosis: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | |
|--|--|
| <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 |

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)	Year Administered (If exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				<input type="checkbox"/> YES <input type="checkbox"/> NO
Pneumococcal (PPSV23)				<input type="checkbox"/> YES <input type="checkbox"/> NO
Pneumococcal (PCV13)				<input type="checkbox"/> YES <input type="checkbox"/> NO
COVID-19	<i>REQUIRED</i> Dose 1: _____ Dose 2: _____	<i>REQUIRED</i> <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Other: _____		<input type="checkbox"/> YES <input type="checkbox"/> NO
Other: _____				<input type="checkbox"/> YES <input type="checkbox"/> NO

*Refers to patient or resident, depending on transferring facility

Name of staff completing form (print): _____ Signature: _____ Date: _____
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If information communicated prior to transfer:

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