Hospital Quality Improvement

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Inter-Facility Infection Control Transfer Form

Best practice recommendation: Complete prior to transfer to accepting facility. If sent with initial referral, update when transfer occurs.
Attach copies of most recent 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

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
List any antibiotics, current or in the previous 6 months, the person* has been prescribed.

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: _____

ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

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