INFECTION CONTROL TRANSFER FORM

This form should be sent with the patient/resident upon transfer. It is NOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Affix any patient labels here.

Demographics

Patient/Resident *(Last Name, First Name)*:		
Date of Birth: / /	**MRN:**	**Transfer Date:** / /
Sending Facility Name:		
Contact Name:	**Contact Phone: ( ) -**	
Receiving Facility Name:		

⚠ **Currently in Isolation Precautions?** □ **Yes**
If Yes, check: □ Contact □ Droplet □ Airborne □ Other: _____

□ **No** isolation precautions

Organisms

Did or does have (send documentation, e.g. culture and antimicrobial susceptibility test results with applicable dates):	Current (or previous) infection or colonization, or ruling out *
MRSA	□
VRE	□
Acinetobacter resistant to carbapenem antibiotics	□
E. coli, *Klebsiella* or *Enterobacter* resistant to carbapenem antibiotics (CRE)	□
E. coli or *Klebsiella* resistant to expanded-spectrum cephalosporins (ESBL)	□
C. difficile	□
Other^: _____ *^e.g. lice, scabies, disseminated shingles, norovirus, flu, TB, etc*	□ **(current or ruling out*)**
***Additional information if known:**	

□ **No** known MDRO or communicable diseases

Symptoms

Check yes to any that currently apply:**

□ Cough/uncontrolled respiratory secretions
□ Incontinent of urine
□ Vomiting
□ Acute diarrhea or incontinent of stool
□ Draining wounds
□ Other uncontained body fluid/drainage
□ Concerning rash (e.g.; vesicular)

****NOTE: Appropriate PPE required ONLY if incontinent/drainage/rash NOT contained.**

□ **No** symptoms / PPE not required as "contained"

PPE

ISOLATION PRECAUTIONS

□ □ □

CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY

Answers to sections above

ANY YES

ALL NO

Person completing form: _____
Role: _____ Date: __/__/__

Other MDRO Risk Factors

Is the patient currently on antibiotics? □ **Yes** □ **No**

Antibiotic	**Dose, Frequency**	**Treatment for:**	**Start date:**	**Stop date:**

Does the patient currently have any of the following devices? □ **Yes** □ **No**

□ Central Line/ PICC, Date inserted: __/__/__
□ Hemodialysis Catheter
□ Urinary Catheter, Date inserted: __/__/__
□ Subrapubic catheter
□ Percutaneous gastrostomy tube
□ Tracheostomy
□ Fecal management system

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Were immunizations received at sending facility? □ **Yes** □ **No**
If yes, specify: _____ Date(s): _____