

## 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*

Patient/Resident Last Name	First Name	Date of Birth
<i>Print or place Patient Label</i>		

Sending Facility Name	Sending Facility Unit	Sending Facility Phone #

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 a multidrug-resistant organism (MDRO), or have an infection with a pathogen requiring transmission-based precautions?	Colonization or history <i>Check if YES</i>	Active infection on treatment <i>Check if YES</i>
<b>MRSA</b> (methicillin-resistant <i>Staphylococcus aureus</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>VRE</b> (Vancomycin-resistant <i>Enterococcus</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. diff</b> ( <i>Clostridiodes difficile</i> , formerly known as <i>Clostridium difficile</i> , CDI)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Acinetobacter spp.</b> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gram-negative organism resistant to multiple antibiotics*</b> (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i> spp.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>CRE</b> (carbapenem-resistant <i>Enterobacteriaceae</i> )	<input type="checkbox"/>	<input type="checkbox"/>
<b>SARS-CoV-2</b> (severe acute respiratory syndrome coronavirus 2)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other**:</b>	<input type="checkbox"/>	<input type="checkbox"/>

\*Culture report with multiple antibiotics marked resistant (R); send copy of report with susceptibilities.

\*\*Other: lice, scabies, shingles, norovirus, influenza, tuberculosis, etc.

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

- |   |  |
|---|--|
| <input type="checkbox"/> Cough or requires suctioning<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Incontinent of urine or stool<br><input type="checkbox"/> Open wounds or wounds requiring dressing change<br><input type="checkbox"/> Drainage (source) _____ | <input type="checkbox"/> Central line/PICC<br><input type="checkbox"/> Hemodialysis catheter<br><input type="checkbox"/> Urinary catheter<br><input type="checkbox"/> Suprapubic catheter<br><input type="checkbox"/> Percutaneous gastrostomy tube<br><input type="checkbox"/> Tracheostomy |
|---|--|

**Notes:**

Printed Name of Person completing form:	Signature:	Date:	Name and phone of individual at receiving facility who received information:

**Important:**

**Must Read**

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