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 test results with applicable dates):	**Current** (or previous infection or colonization, or ruling out*)
Acinetobacter resistant to carbapenem antibiotics (CRA)	☐
E. coli, *Klebsiella* or *Enterobacter* resistant to carbapenem antibiotics (CRE)	☐
Pseudomonas aeruginosa resistant to carbapenem antibiotics (CRPA)	☐
Carbapenemase production in any of the above organisms (CP +)	☐
MRSA	☐
VRE	☐
E. coli, *Klebsiella* resistant to expanded-spectrum cephalosporins (ESBL)	☐
C. difficile	☐
Other^: *^e.g. C. auris, C. haemulonii, lice, scabies, disseminated shingles, norovirus, influenza, 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
☐ Concerning rash (e.g.; vesicular)
☐ Acute diarrhea or incontinent stool
☐ Draining wounds
☐ Other uncontained bodily fluid/drainage

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

☐ **No** Symptoms / PPE not required as "contained"

PPE

PERSONAL PROTECTIVE EQUIPMENT CONSIDERATIONS

☐ ☐ ☐

CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY

ANY YES ← **Answers to sections above** → **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:
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Tracheostomy
☐ Fecal management system

Immunizations

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