HEALTHCARE FACILITY TRANSFER FORM (ENHANCED)
Use this form for all transfers to an admitting healthcare facility.

Patient Name (Last, First):

Date of Birth:  
MRN:  
Transfer Date:  

Receiving Facility Name: 

Sending Facility Name: 

Contact Name:  
Contact Phone:  

Patient currently on isolation precautions?

☐ Yes  ☐ No

If yes, check all that apply:

☐ Contact precautions
☐ Droplet precautions
☐ Airborne precautions

Personal protective equipment (PPE) to consider at receiving facility:

☐ Gloves  ☐ Gowns  ☐ Masks

Patient has multidrug-resistant organism (MDRO) or other lab results for which the patient should be in isolation?

☐ Yes  ☐ No

If yes, specify organism(s) and include specimen source and collection date.

<table>
<thead>
<tr>
<th>Organism</th>
<th>Source</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ C.difficile</td>
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<tr>
<td>☐ Carbapenem-resistant Enterobacteriaceae (CRE) (e.g., Klebsiella, Enterobacter or E.coli)</td>
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<td>☐ Extended-spectrum beta lactam-resistant (ESBL) (e.g., E.coli, Klebsiella)</td>
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<tr>
<td>☐ MDR gram negatives (e.g., Acinetobacter, Pseudomonas)</td>
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<tr>
<td>☐ Methicillin-resistant Staphylococcus aureus (MRSA)</td>
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<td>☐ Vancomycin-resistant Enterococcus (VRE)</td>
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<tr>
<td>Other, specify: e.g., lice, scabies, disseminated shingles (Herpes zoster), norovirus, influenza, tuberculosis</td>
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Include copy of lab results with antimicrobial susceptibilities.
### Symptoms

Patient has any of the following symptoms?

- [ ] Yes  [ ] No

If yes, check all that currently apply:

- [ ] Cough/uncontrolled respiratory secretions
- [ ] Rash consistent with an infectious process (e.g., vesicular)
- [ ] Vomiting
- [ ] Draining wounds
- [ ] Acute diarrhea or incontinent stool
- [ ] Other uncontained bodily fluid / drainage
- [ ] Incontinent of urine

### Antibiotics

Patient is currently on antibiotics?

- [ ] Yes  [ ] No

If yes, specify:

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Dose</th>
<th>Frequency</th>
<th>Indication</th>
<th>Start Date</th>
<th>Stop Date</th>
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### Devices

Patient currently has any of the following devices?

- [ ] Yes  [ ] No

If yes, check all that currently apply:

- [ ] Central line/PICC, Date inserted:  
- [ ] Tracheostomy
- [ ] Hemodialysis catheter
- [ ] Urinary catheter, Date inserted:
- [ ] Fecal management system
- [ ] Suprapubic catheter
- [ ] Percutaneous gastrostomy feeding tube

### Immunizations

Patient received immunizations at the sending facility?

- [ ] Yes  [ ] No

If yes, specify:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date(s)</th>
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