

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 No
 If Yes, check: Contact Droplet Airborne Other: _____
 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*)	
MRSA	<input type="checkbox"/>	<input type="checkbox"/> No known MDRO or communicable diseases
VRE	<input type="checkbox"/>	
<i>Acinetobacter</i> resistant to carbapenem antibiotics	<input type="checkbox"/>	
<i>E. coli</i> , <i>Klebsiella</i> or <i>Enterobacter</i> resistant to carbapenem antibiotics (CRE)	<input type="checkbox"/>	
<i>E. coli</i> , <i>Klebsiella</i> resistant to expanded-spectrum cephalosporins (ESBL)	<input type="checkbox"/>	
<i>C. difficile</i>	<input type="checkbox"/>	
Other^: ^e.g. lice, scabies, disseminated shingles, norovirus, influenza, TB, etc.	<input type="checkbox"/> (current or ruling out*)	
*Additional information if known: _____		

Symptoms


Check yes to any that currently apply:**


<input type="checkbox"/> Cough/uncontrolled respiratory secretions	<input type="checkbox"/> Concerning rash (e.g.; vesicular)	<input type="checkbox"/> No Symptoms / PPE not required as "contained"
<input type="checkbox"/> Incontinent of urine	<input type="checkbox"/> Acute diarrhea or incontinent stool	
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Draining wounds	
	<input type="checkbox"/> Other uncontained bodily fluid/drainage	


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

<input type="checkbox"/> Central line/PICC, Date inserted: _____	<input type="checkbox"/> Suprapubic catheter	<input type="checkbox"/> Fecal management system
<input type="checkbox"/> Hemodialysis catheter	<input type="checkbox"/> Percutaneous gastrostomy tube	
<input type="checkbox"/> Urinary catheter, Date inserted: _____	<input type="checkbox"/> Tracheostomy	

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Were immunizations received at sending facility? Yes No

If yes, specify: _____ Date(s): _____