Affix patient labels here.

HEALTHCARE FACILITY TRANSFER FORM (COMPREHENSIVE)

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:

ISOLATION PRECAUTIONS

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

ORGANISMS

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.

Organism	Source	Date
☐ *C.difficile*		
☐ Carbapenem-resistant *Enterobacteriaceae* (CRE) (e.g., *Klebsiella*, *Enterobacter* or *E.coli*)		
☐ Extended-spectrum beta lactam-resistant (ESBL) (e.g., *E.coli*, *Klebsiella*)		
☐ MDR gram negatives (e.g., *Acinetobacter*, *Pseudomonas*)		
☐ Methicillin-resistant *Staphylococcus aureus* (MRSA)		
☐ Vancomycin-resistant *Enterococcus* (VRE)		
☐ Other, specify: (e.g., lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis)		

Include copy of **lab results** with organism I.D. and antimicrobial susceptibilities.

Affix patient labels here.

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
☐ Acute diarrhea or incontinent stool
☐ Draining wounds
☐ Incontinent of urine
☐ Other uncontained bodily fluid / drainage

ANTIBIOTICS

Patient is currently on antibiotics?

☐ **Yes** ☐ **No**

If yes, specify:

Antibiotic	Dose	Frequency	Indication	Start Date	Stop Date

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:

Vaccine	Date(s)