

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? <input type="checkbox"/> Yes If Yes, check: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Other: _____	<input type="checkbox"/> No isolation precautions
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Organisms	Did or does have (send documentation, e.g. culture and antimicrobial susceptibility test results with applicable dates):	Current (or previous) infection or colonization, or ruling out *	<input type="checkbox"/> No known MDRO or communicable diseases
	MRSA	<input type="checkbox"/>	
	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> or <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"/> Acute diarrhea or incontinent of stool <input type="checkbox"/> Incontinent of urine <input type="checkbox"/> Draining wounds <input type="checkbox"/> Vomiting <input type="checkbox"/> Other uncontained body fluid/drainage <input type="checkbox"/> Concerning rash (e.g.; vesicular)	<input type="checkbox"/> No symptoms / PPE not required as "contained"
	**NOTE: Appropriate PPE required ONLY if incontinent/drainage/rash NOT contained.	

PPE	PERSONAL PROTECTIVE EQUIPMENT CONSIDERATIONS <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/></div> <div style="text-align: center;"> <input type="checkbox"/></div> <div style="text-align: center;"> <input type="checkbox"/></div> </div> <p style="text-align: center; margin-top: 5px;">CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY</p>	<div style="border: 1px solid black; padding: 5px; margin: 0 auto; width: 80%;"> <p>Answers to sections above</p> <p>ANY YES →</p> <p>ALL NO ↓</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px; width: 80%;"> <p>Person completing form: _____</p> <p>Role: _____ Date: _____</p> </div>

Other MDRO Risk Factors	Is the patient currently on antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Antibiotic: _____	Dose, Frequency: _____	Treatment for: _____	Start date: _____	Stop date: _____
	Does the patient currently have any of the following devices? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Central line/PICC, Date inserted: _____		<input type="checkbox"/> Suprapubic catheter		
	<input type="checkbox"/> Hemodialysis catheter		<input type="checkbox"/> Percutaneous gastrostomy tube		
<input type="checkbox"/> Urinary catheter, Date inserted: _____		<input type="checkbox"/> Tracheostomy			
		<input type="checkbox"/> Fecal management system			

IZ	Were immunizations received at sending facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____ Date(s): _____
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