# HEALTHCARE FACILITY TRANSFER FORM

Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

| **Patient Name** (Last, First): | | |
|---|---|---|
| Date of Birth: | MRN: | Transfer Date: |
| **Receiving Facility** Name (if known): _____ Contact Name (optional): _____ Contact Phone (optional): _____ | | |
| **Sending Facility** Name: _____ Contact Name: _____ Contact Phone: _____ | | |

**PRECAUTIONS**

| **Patient currently on precautions?** | If yes, check all that apply: |
|---|---|
| ☐ **Yes** ☐ **No** | ☐ Airborne ☐ Contact ☐ Droplet ☐ Enhanced Standard* |

*Long-term care facilities may implement Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx) for patients with multidrug-resistant organisms (MDROs) or risk factors for transmission, i.e., gown and glove use for high-contact care activities; such patients may be on Contact Precautions in acute care settings.

**ORGANISMS** (Include copy of **lab results** with organism ID and antimicrobial susceptibilities.)

☐ **Patient is NOT known to be colonized or infected with any multidrug-resistant or other organisms requiring precautions (*skip section*)**

☐ **Patient has MDRO or other lab results requiring precautions** (record organism(s), specimen source, collection date)

☐ **Exposed to MDRO/other** (record organism(s) and last date(s) of exposure if known)

| Organism | Carbapenemase (if applicable)** | Source | Date |
|---|---|---|---|
| ☐ *Candida auris* (***C. auris***) | | | |
| ☐ *Clostridiodes difficile* (***C. diff***) | | | |
| ☐ *Acinetobacter*, multidrug-resistant (e.g., **CRAB****) | | | |
| ☐ Carbapenem-resistant Enterobacterales (**CRE****) | | | |
| ☐ *Pseudomonas aeruginosa,* multidrug-resistant (e.g., **CRPA****) | | | |
| ☐ Extended-spectrum beta-lactamase (**ESBL**)-producer | | | |
| ☐ Methicillin-resistant *Staphylococcus aureus* (**MRSA**) | | | |
| ☐ Vancomycin-resistant *Enterococcus* (**VRE**) | | | |
| ☐ No organism identified (e.g., molecular screening test**) | | | |
| ☐ **Other, specify**: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis) | | | |

**Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known

Affix patient labels here.

## CLINICAL STATUS

**Patient has any of the following symptoms or clinical status?**

☐ **Yes** ☐ **No**

If yes, check all that currently apply:

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

## ANTIBIOTICS/ANTIFUNGALS

**Patient is currently on antibiotics/systemic antifungals?**

☐ **Yes** ☐ **No**

If yes, specify:

| Antibiotic/Antifungal | 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:
☐ Hemodialysis catheter
☐ Fecal management system
☐ Percutaneous gastrostomy feeding tube
☐ Wound VAC
☐ Tracheostomy
☐ Urinary catheter, Date inserted:
☐ Suprapubic catheter
☐ Mechanical ventilation

## IMMUNIZATION STATUS

**Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)**

☐ **Yes (specify below)** ☐ **No**

| Vaccine | Date(s) |
|---|---|
| | |
| | |
| | |
| | |

[§] Risk factors for MDRO transmission per Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx)