



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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Organism	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
	COVID-19		
	MRSA		
	VRE		
	<i>Acinetobacter</i> resistant to carbapenem antibiotics		
	<i>E. coli, Klebsiella</i> or <i>Enterobacter</i> resistant to carbapenem antibiotics (CRE)		
	<i>E. coli</i> or <i>Klebsiella</i> resistant to expanded-spectrum cephalosporins (ESBL)		
	<i>C. difficile</i>		
	<i>C. auris</i>		
	Other^: _____ ^e.g. lice, scabies, disseminated shingles, norovirus, flu, TB, etc		
*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	ISOLATION PRECAUTIONS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Answers to sections above ANY YES ALL NO
	CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY	Person completing form: _____ Role: _____ Date: _____

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:

Other MDRO Risk Factors	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"/> Hemodialysis Catheter <input type="checkbox"/> Urinary Catheter, Date inserted:	<input type="checkbox"/> Subrapubic catheter <input type="checkbox"/> Percutaneous gastrostomy tube <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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