



Inter-facility Infection Control Transfer Form

This form must be completed and communicated to accepting facility prior to or during transfer of patient or resident with multidrug-resistant organism (MDRO) infection or colonization.

Please attach copies of latest culture reports with susceptibilities if available.

Date of Transfer: ___/___/___

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number
		___/___/___	

Sending Healthcare Facility	Address	Phone	Contact Person

Is the patient currently on isolation precautions? No Yes
Type of Isolation (check all that apply) Contact Droplet Airborne Other: _____

Does patient currently have an infection, colonization OR a history of positive culture of a MDRO or other organism of significance?	Colonization or history <i>Check if Yes</i>	Active infection <i>List infections</i>
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter, multidrug-resistant*		
E coli, Klebsiella, etc. w/Extended Spectrum B-Lactamase (ESBL)*		
Carbapenem-resistant Enterobacteriaceae (CRE)*		
Other:		

Does the patient/resident currently have any of the following?

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Cough or requires suctioning
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Incontinent of urine or stool
<input type="checkbox"/> Open wounds or wounds requiring dressing change
<input type="checkbox"/> Drainage (source) _____ | <input type="checkbox"/> Central line/PICC (Date inserted ___/___/___)
<input type="checkbox"/> Hemodialysis catheter
<input type="checkbox"/> Urinary catheter (Date inserted ___/___/___)
<input type="checkbox"/> Suprapubic catheter
<input type="checkbox"/> Percutaneous gastrostomy tube
<input type="checkbox"/> Tracheostomy |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Is the patient/resident currently on antibiotics? No Yes:

Antibiotic and dose	Treatment for:	Start date	Duration

Comments:

Name of person completing form	Date	Name and phone of contact person at receiving facility (if communicated prior to transfer)

**Adapted from Utah State Department of Health. For more information please visit:
<http://www.cdc.gov/hai/index.html> or <https://hip.phila.gov/xv/DiseaseInformation/CRE>*