Facility Logo

Inter-facility Infection Control Transfer Form

SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY

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

Patient/Resident Last Name	First Name	Date of Birth
Print or place Patient Label		

Sending Facility Name	Sending Facility Unit	Sending Facility Phone #

Is the patient/resident currently on antibiotics? □ **NO** □ **YES** **DX:** _____

Does the patient/resident have pending cultures? □ **NO** □ **YES**

Is the patient/resident currently on precautions? □ **NO** □ **YES**

Type of Precautions (check all that apply) □ **Contact** □ **Droplet** □ **Airborne** □ **Other:**_____

Does patient currently have an infection, colonization, or a history of a multidrug-resistant organism (MDRO), or have an infection with a pathogen requiring transmission-based precautions?	**Colonization or history** *Check if YES*	**Active infection on treatment** *Check if YES*
MRSA (methicillin-resistant *Staphylococcus aureus)*	☐	☐
VRE (Vancomycin-resistant *Enterococcus*)	☐	☐
C. diff (*Clostridiodes difficile, formerly known as Clostridium difficile, CDI*)	☐	☐
***Acinetobacter* spp.,** multidrug-resistant	☐	☐
Gram-negative organism resistant to multiple antibiotics* (e.g., *E. coli, Klebsiella, Proteus* spp.)	☐	☐
CRE (carbapenem-resistant *Enterobacterales*)	☐	☐
SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2)	☐	☐
Candida auris	☐	☐
Other:**	☐	☐

*Culture report with multiple antibiotics marked resistant (R); send copy of report with susceptibilities.
**Other: lice, scabies, shingles, norovirus, influenza, tuberculosis, etc.

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

☐ Cough or requires suctioning
☐ Diarrhea
☐ Vomiting
☐ Incontinent of urine or stool
☐ Open wounds or wounds requiring dressing change
☐ Drainage (source)_____
☐ Central line/PICC
☐ Hemodialysis catheter
☐ Urinary catheter
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Tracheostomy

Notes:

Printed Name of Person completing form:	**Signature:**	**Date:**	**Name and phone of individual at receiving facility who received information:**

Important:

Must Read

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