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? □ **Yes - Reason**_____
If Yes, check: □ Contact □ Droplet □ Airborne □ Other: _____

□ **No** isolation precautions

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 pending results*	□ **No** known MDRO or communicable diseases
MRSA/VRE	□	
Candida auris	□	
Pseudomonas or Acinetobacter resistant to carbapenem antibiotics (CRAB/CRPA)	□	
E. coli, *Klebsiella* or *Enterobacter* resistant to carbapenem antibiotics (CRE)	□	
E. coli or *Klebsiella* producing extended-spectrum beta lactamase (ESBL)	□	
C. difficile	□	
Other^: _____ *^e.g. lice, scabies, disseminated shingles, norovirus, flu, TB, etc*	□ **(current or pending results)**	
***Additional information if known:**		

Symptoms

Check yes to any that <u>currently</u> apply:

□ Cough/uncontrolled respiratory secretions
□ Incontinent of urine
□ Vomiting
□ Acute diarrhea or incontinent of stool
□ Draining wounds
□ Other uncontained body fluid/drainage
□ Concerning rash (e.g.; vesicular)

□ **None**

Person completing form:_____

Role:_____

Date:_____