Indiana State Department of Health

Inter-Facility Infection Control Transfer Form

This Inter-Facility Infection Control patient transfer form can assist in fostering communication during transitions of care for patients colonized or infected with a multidrug-resistant organism. Discharging facility should complete this transfer from and sign at the bottom after all fields are completed. Attach copy of records and latest laboratory reports with susceptibilities going with the patient to receiving facility. This form has been adapted from the Centers for Disease Control and Prevention (CDC).

Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer.

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

Sending Healthcare Facility:

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

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Contact Name	Phone	E-mail
Transferring RN/Unit			
Transferring physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonization or history (*Check if YES*)	Active infection on Treatment (*Check if YES*)
Methicillin-resistant *Staphylococcus aureus* (MRSA)	☐ Yes	☐ Yes
Vancomycin-resistant *Enterococcus* (VRE)	☐ Yes	☐ Yes
Clostridioides difficile	☐ Yes	☐ Yes
Acinetobacter, multidrug-resistant	☐ Yes	☐ Yes
Enterobacteriaceae (e.g., *E. coli, Klebsiella, Proteus*) producing-Extended Spectrum Beta-Lactamase (ESBL)	☐ Yes	☐ Yes
Carbapenem-resistant Enterobacteriaceae (CRE)	☐ Yes	☐ Yes
Pseudomonas aeruginosa, multidrug-resistant	☐ Yes	☐ Yes
Candida auris	☐ Yes	☐ Yes
Other, specify (e.g., lice, scabies, norovirus, influenza):	☐ Yes	☐ Yes

Does the person* currently have any of the following? (Check here ☐ if none apply)

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

Inter-facility Infection Control Transfer Form

Is the person* currently in Transmission-Based Precautions? ☐ NO ☐ YES

Type of Precautions (check all that apply) ☐ Contact ☐ Droplet ☐ Airborne

☐ Other:

Reason for Precautions:

Is the person* currently on antibiotics? ☐ **NO** ☐ **YES (current use)**

Antibiotic, dose, route, freq.	Treatment for:	Start date	Anticipated stop date	Date/time last dose

Vaccine	Date administered (If known)	Lot and Brand (If known)	Year administered (If exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				☐ Yes ☐ No
Pneumococcal (PPSV23)				☐ Yes ☐ No
Pneumococcal (PCV13)				☐ Yes ☐ No
Other:				☐ Yes ☐ No

*Refers to patient or resident depending on transferring facility

Required PPE

☐  ☐  ☐ 

Name of staff completing form (print):

Signature:

If information communicated prior to transfer:

Name of individual at receiving facility:

Phone of individual at receiving facility: