



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 form and sign at the bottom after all fields are completed. Attach copy of records and latest laboratory reports with susceptibilities going with patient to receiving facility.

INFECTION CONTROL TRANSFER FORM

(Discharging Facility to complete form and communicate information to Receiving Facility)

Demographics	Patient/Resident		Date of Birth:	MRN:	Discharge Date:
	<i>Last Name</i>	<i>First Name</i>			
	Sending Facility Name:		Contact Name:		Contact Phone:
	Receiving Facility Name:				

Precautions	Currently in Isolation Precautions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If Yes check: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Other: _____			

Organisms	Did or does have (send documentation):		<input type="checkbox"/> No	
	Multiple Drug Resistant Organism (MDRO):			<input type="checkbox"/> Yes
	MRSA			<input type="checkbox"/>
	VRE			<input type="checkbox"/>
	Acinetobacter not susceptible to carbapenems			<input type="checkbox"/>
	Carbapenemase-producing CRE (CP-CRE)			<input type="checkbox"/>
	C. difficile			<input type="checkbox"/>
	Other[±]: _____ <small>± e.g., lice, scabies, disseminated shingles, norovirus, flu, TB, etc.</small>			<input type="checkbox"/>

Symptoms	Check yes to any that <u>currently</u> apply*):				<input type="checkbox"/> No
	<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			

ISOLATION PRECAUTIONS







CHECK IF INDICATED

Answers to sections above

ANY YES:
Check Required PPE

ALL NO:
Just sign form

Person completing form: _____

Role: _____ Date: ____/____/____