Inter-facility Infection Prevention Transfer Form

When transferring a patient/resident, please complete to the best of your ability to assist with care transitions. **Please send copies** of any relevant **microbiology cultures**, **pending labs, medication administration record (MAR)** or **physician order sheet** (POS), and **immunization documentation.**

Patient Information

Last Name ______________________________First Name_________________________ Date of Birth / /

Room number at time of transfer: ___________

Isolation Precautions: CDC guidelines https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

The patient/resident currently requires the following type(s) of isolation precautions.

☐Contact precautions. Reason: See organism(s) under Infection/Colonization History section

☐Droplet precautions. Circle Reason: Influenza, other: ___________

☐ Suspected or ☐ Confirmed

☐Airborne precautions. Circle Reason: Pulmonary Tuberculosis, Measles, Varicella Zoster Virus.

NOTE: When using Airborne precautions, a verbal report is required.

☐ Suspected or ☐ Confirmed

☐ Droplet/Contact. Circle Reason: RSV, parainfluenza, adenovirus, human metapneumovirus, other: ______

☐ COVID-19 (use N95 respirator or higher respiratory protection)

☐Enhanced Barrier Precautions. ☐ Organism Based or ☐ Risk Based

☐**The patient/resident DOES NOT require precautions.**

Infection/Colonization History: (check all that apply) ☐DOES NOT APPLY *Add Culture Dates(s) if known.

☐MRSA (Methicillin-resistant *Staphylococcus aureus*) or ☐ VRE (Vancomycin-resistant enterococci) *___________

☐*Clostridioides difficile* *___________ ☐ PCR ☐ Toxin ☐ Unknown

☐*Candida auris* *___________

☐Any MDRO gram-negative bacteria (multidrug-resistant). If known, please also specify: *___________

☐Carbapenem-resistant *Enterobacterales* (examples: *Klebsiella* or *E. coli* with KPC, NDM-1) *___________

☐*Acinetobacter*, multidrug-resistant *___________

☐ESBL (extended spectrum beta-lactamase) bacteria *___________

☐*Pseudomonas aeruginosa*, multidrug-resistant *___________

☐Other: *___________

Lab Results: ☐ In chart ☐ Pending results (list) ___________

Antibiotics: ☐ Patient/resident not on ABX ☐Antibiotic ___________ Start date: ___________ Stop date: ___________

Reason for antibiotics: ____

Immunizations/TB (tuberculosis) Screening:

☐ Recent TB Screening (date (s)) ___________ Result ___________☐ TST (tuberculin skin test) ☐ Blood assay

☐ Influenza (date) ____________________

☐ Pneumococcal (indicate type– PCV13, PCV15, PCV20, and/or PPSV23 and date/s) _________________________

☐RSV (date) ___________ ☐COVID-19 (last dates) ____________________ ____________________

☐ Shingrix (date (s)) ___________ ___________

Sending Facility: Person Completing Form (add name here)______________________________________

Facility Contacts	**Contact Name**	**Phone**
Transferring RN/Unit		
Infection Preventionist		

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