Original concept and form developed by Utah HAI Working Group/ Courtesy of Utah State Dept of Health.

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	NAME	PHONE	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient currently in isolation? □ **NO** □ **YES**

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

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or history** *Check if YES*	**Active infection on Treatment** *Check if YES*
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter, multidrug-resistant*		
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)*		
Carbapenemase resistant Enterobacteriaceae (CRE)*		
Other:		

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 (Approx. date inserted ___/___/_____)
- ☐ Hemodialysis catheter
- ☐ Urinary catheter (Approx. date inserted ___/___/_____)
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Tracheostomy

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

Antibiotic and dose	**Treatment for:**	**Start date**	**Anticipated stop date**

Vaccine	**Date administered (If known)**	**Lot and Brand (If known)**	**Year administered (If exact date not known)**	**Does Patient self report receiving vaccine?**	
Influenza (seasonal)				○ yes	○ no
Pneumococcal				○ yes	○ no
Other:_____				○ yes	○ no

Printed Name of Person completing form	**Signature**	**Date**	**If information communicated prior to transfer: Name and phone of individual at receiving facility**