



Inter-Facility Infection Control Transfer Form for States Establishing HAI Prevention Collaboratives

Available from: https://www.cdc.gov/hai/prevent/prevention_tools.html

This example Inter-facility Infection Control patient transfer form can assist in fostering communication during transitions of care. This concept and draft was developed by the Utah Healthcare-associated Infection (HAI) working group and shared with Centers for Disease Control and Prevention (CDC) and state partners courtesy of the Utah State Department of Health.

This tool can be modified and adapted by facilities and other quality improvement groups engaged in patient safety activities.

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 <i>Staphylococcus aureus</i> (MRSA)	Yes	Yes
Vancomycin-resistant <i>Enterococcus</i> (VRE)	Yes	Yes
<i>Clostridioides difficile</i>	Yes	Yes
<i>Acinetobacter</i> , multidrug-resistant	Yes	Yes
Enterobacteriaceae (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i>) producing-Extended Spectrum Beta-Lactamase (ESBL)	Yes	Yes
Carbapenem-resistant Enterobacteriaceae (CRE)	Yes	Yes
<i>Pseudomonas aeruginosa</i> , multidrug-resistant	Yes	Yes
<i>Candida auris</i>	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 | Central line/PICC (Approx. date inserted) |
| Diarrhea | Hemodialysis catheter |
| Vomiting | Urinary catheter (Approx. date inserted) |
| Incontinent of urine or stool | Suprapubic catheter |
| Open wounds or wounds requiring dressing change | Percutaneous gastrostomy tube |
| Drainage (source): | 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

Name of staff completing form (print):

Signature:

Date :

If information communicated prior to transfer:

Name of individual at receiving facility:

Phone of individual at receiving facility: