Inter-facility Infection Prevention Transfer Form

When transferring patient/resident, please complete to the best of your ability to assist with care transitions.

Patient Information

Last Name _____ First Name _____

Date of Birth _____/_____/_____

Isolation Precautions

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

□ Contact precautions. Reason: _____

□ Droplet precautions. Reason: _____

□ Airborne precautions. Reason: _____

□ The patient DOES NOT require isolation.

Infection/Colonization History (check all that apply)

□ MRSA (Methicillin-resistant *Staphylococcus aureus*)

□ VRE (Vancomycin-resistant enterococci)

□ *Clostridium difficile*

□ *Candida auris*

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

- □ Carbapenem-resistant *Enterobacteriaciae* (examples: *Klebsiella* or *E. coli* with KPC, NDM-1)
- □ *Acinetobacter*, multidrug-resistant
- □ ESBL (extended spectrum beta-lactamase) bacteria
- □ *Pseudomonas aeruginosa*, multidrug-resistant

□ Respiratory Illness (influenza, adenovirus, etc., suspected or confirmed) — Droplet Precautions

□ Respiratory Illness (tuberculosis , etc., suspected or confirmed) — Airborne Precautions

□ Any other pathogen requiring isolation. Please list: _____

Sending Facility Information

Facility Name _____ Unit_____

Address _____ Phone _____

Person Completing Form

Name/Title _____

Phone _____

Email/Fax _____

Infection Prevention Designee

Name _____

Phone _____

Email/Fax _____

Please send copies of any relevant microbiology cultures, medication administration record (MAR) or physician order sheet (POS), and immunization documentation.