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.

Updated: 12/11/2018

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 *Staphylococcus aureus* (MRSA)		
Vancomycin-resistant *Enterococcus* (VRE)		
Clostridioides difficile		
Acinetobacter, multidrug-resistant		
Enterobacteriaceae (e.g., *E. coli*, *Klebsiella*, *Proteus*) producing-Extended Spectrum Beta-Lactamase (ESBL)		
Carbapenem-resistant Enterobacteriaceae (CRE)		
Other, specify (e.g., lice, scabies, norovirus, influenza):		

Does the person* currently have any of the following? (Check here ☐ if none apply)

☐ 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 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

Name of staff completing form (print)	Signature	Date	If information communicated prior to transfer: Name and phone of individual at receiving facility

*Refers to patient or resident depending on transferring facility