

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