Sample Inter-Facility Infection Control Transfer Form

This example Inter-facility Infection Control patient transfer form can assist in fostering communication during transitions of care. This concept and an initial draft were 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	Email
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 (*Mark if YES*)	Active infection (*Mark 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)		
Pseudomonas aeruginosa, multidrug-resistant		
Candida auris		
Other, specify (e.g., lice, scabies, norovirus, influenza, COVID-19):		

Does the person* currently have any of the following?	*Mark if YES*
Cough or requires suctioning	
Diarrhea	
Vomiting	
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	

Mark here if none of the above apply: ____

Is the person* currently in Transmission-Based Precautions? ____NO **____**YES

Type of Precautions (mark all that apply):

Contact	**Droplet**	**Airborne**	**Enhanced Barrier Precautions**	**Other: _____**

Reason for Precautions: _____

Is the person* currently on antibiotics, antifungals, or antivirals? ____NO **____**YES (current use)

Name, 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)**	**Person* self-reports receiving vaccine (*Mark if YES)*
Influenza (seasonal)				
COVID-19				
Pneumococcal				
RSV				
Other:_____				
Other:_____				

*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:_____

Remember to save or print form.