INFECTION CONTROL TRANSFER FORM

This form should be sent with the patient/resident upon transfer.
https://acphd.org/cro/

Affix patient label here

Demographics

Patient/Resident *(Last Name, First Name)*:

Date of Birth: | **Transfer Date:**

Sending Facility Name:

Transferring Facility Type:
*Please select as applicable based on licensing designation

- ☐ Acute Care Hospital
- ☐ Long Term Acute Care Hospital
- ☐ Ventilator Equipped SNF(Sub-acute)
- ☐ Skilled Nursing Facility
- ☐ Residential Care for Elderly/Assisted Living/Memory Care
- ☐ Other:

Is sending facility in current/Suspected Outbreak? ☐Yes ☐No If yes, specify type of outbreak:

Contact Name: | **Contact Phone:**

Receiving Facility Name:

Has receiving facility been notified? ☐Yes ☐No

Precautions and PPE

Currently in Isolation Precautions? ☐ Yes ☐ No
If Yes, check:

☐ Contact ☐ Droplet
☐ Airborne ☐ Enhanced Standard*

PERSONAL PROTECTIVE EQUIPMENT CONSIDERATIONS
CHECK ALL PPE TO BE CONSIDERED AT RECEIVING FACILITY

☐ Masks ☐ Gloves ☐ Gowns ☐ N95
☐ PAPR ☐ Eye Protection

Organisms

ORGANISMS (Include copy of **lab results** with organism ID and antimicrobial susceptibilities.)

☐ Patient is **NOT** known to be colonized or infected with any multidrug-resistant or other organisms requiring precautions (*skip)*
☐ Patient has MDRO or other lab results requiring precautions (record organism(s), specimen source, collection date)
☐ Exposed to MDRO/other (record organism(s) and last date(s) of exposure if known)

Organism	Carbapenemase (if applicable)**	Source	Date
☐ *Candida auris* (***C. auris***)			
☐ *Clostridioides difficile* (***C. diff***)			
☐ *Acinetobacter baumannii*, multidrug-resistant (e.g., **CRAB****)			
☐ Carbapenem-resistant Enterobacterales (**CRE****)			
☐ *Pseudomonas aeruginosa,* multidrug-resistant (e.g., **CRPA****)			
☐ Extended-spectrum beta-lactamase (**ESBL**)-producer			
☐ Methicillin-resistant *Staphylococcus aureus* (**MRSA**)			
☐ Vancomycin-resistant *Enterococcus* (**VRE**)			
☐ Positive molecular screening test, organism unknown**			
☐ **Other, specify**: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis)			

**Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known

Symptoms/Risk Factors for Transmission

Check yes to any that <u>currently</u> apply:**

- ☐ Cough/uncontrolled respiratory secretions
- ☐ Incontinent of urine
- ☐ Vomiting
- ☐ Concerning rash (e.g., vesicular)
- ☐ Acute diarrhea or incontinent of stool
- ☐ Draining wounds
- ☐ Other uncontained bodily fluid/drainage

****NOTE: Appropriate PPE required if incontinent/drainage/rash NOT contained.**

☐ No Symptoms requiring additional PPE

Does the patient currently have any of the following devices? **☐ Yes ☐ No**

- ☐ Tracheostomy/Endotracheal tube
- ☐ Central line/PICC, Date inserted:
- ☐ Urinary catheter, Date inserted:
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Hemodialysis catheter
- ☐ Colostomy
- ☐ Rectal tube