



**INTER-FACILITY INFECTION CONTROL TRANSFER FORM
FOR STATES ESTABLISHING HAI PREVENTION COLLABORATIVES
USING ARRA FUNDS**

This example Inter-facility Infection Control transfer form is being sent to state health departments for use in your Prevention Collaborative facilities to 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 states for use by participating facilities engaged in Prevention Collaborative activities. In particular, this could be a communication resource for identifying infection control/HAI issues relevant to non-acute care settings such as long-term care facilities at the time of transfer from the acute care setting.

If you have any questions or suggestions, please feel free to contact your CDC Prevention Liaison or Public Health Analyst.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION**

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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	NAME	PHONE	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient currently in isolation? NO YES

Type of Isolation (check all that apply) Contact Droplet Airborne Other:

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Colonization or history <i>Check if YES</i>	Active infection on Treatment <i>Check if YES</i>
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter, multidrug-resistant*		
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)*		
Carbapenemase resistant Enterobacteriaceae (CRE)*		
Other:		

Does the patient/resident currently have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Cough or requires suctioning | <input type="checkbox"/> Central line/PICC (Approx. date inserted ___/___/_____) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemodialysis catheter |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary catheter (Approx. date inserted ___/___/_____) |
| <input type="checkbox"/> Incontinent of urine or stool | <input type="checkbox"/> Suprapubic catheter |
| <input type="checkbox"/> Open wounds or wounds requiring dressing change | <input type="checkbox"/> Percutaneous gastrostomy tube |
| <input type="checkbox"/> Drainage (source)_____ | <input type="checkbox"/> Tracheostomy |

Is the patient/resident currently on antibiotics? NO YES:

Antibiotic and dose	Treatment for:	Start date	Anticipated stop date

Vaccine	Date administered (If known)	Lot and Brand (If known)	Year administered (If exact date not known)	Does Patient self report receiving vaccine?	
Influenza (seasonal)				<input type="radio"/> yes	<input type="radio"/> no
Pneumococcal				<input type="radio"/> yes	<input type="radio"/> no
Other:_____				<input type="radio"/> yes	<input type="radio"/> no

Printed Name of Person completing form	Signature	Date	If information communicated prior to transfer: Name and phone of individual at receiving facility