Inter-Facility Infection Prevention Transfer Tool



This tool can be used for transferring a patient or resident to the receiving facility. The information provided in this tool should be communicated prior to or during transfer. Delays in communication can lead to delays in patient or resident care.

**For assistance, please contact the DHSS HAI/AR Program: Phone: 573.751.6113 Email:** [**HAI\_Reporting@health.mo.gov**](mailto:HAI_Reporting@health.mo.gov)

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| **Patient/Resident Information** | | | | | | | | | | | | | | | | | | | | | |
| *Last Name* | | | | | *First Name* | | | | | *Date of Birth* | | | | *Medical Record/ID Number* | | | | | | | |
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| **Sending/Transferring Facility Information** | | | | | | | | | | | | | | | | | | | | | |
| *Transfer Date* | | | | | *Transferring Facility Name, City/State* | | | | | | | | | | | | | | | | |
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| *Transferring Facility Point of Contact and Phone Number* | | | | | | | | | | | | | | | | | | | | | |
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| *Receiving Facility Name, Point of Contact and Phone Number* | | | | | | | | | | | | | | | | | | | | | |
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| **Isolation Precaution Status** | | | | | | | | | | | | | | | | | | | | | |
| Is the patient/resident currently on isolation precautions? | | | | | | | | | | | | | □ YES | | | | | | | □ NO | |
| If yes, please indicate the type of isolation precaution required | | | | | | | | | | | | | | | | | | | | | |
| [Enhanced Barrier](https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html)  (USE IN LTC ONLY) | | Contact | | | | Contact w/ Hand Hygiene | | | | | Droplet | | | | | | | | Airborne | | |
| □ | | □ | | | | □ | | | | | □ | | | | | | | | □ | | |
| Please provide the indication for the required isolation precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **Infectious Disease History** | | | | | | | | | | | | | | | | | | | | | |
| Does the patient/resident have a significant history or positive culture related to multidrug-resistant organisms (MDROs) or other transmissible organisms? | | | | | | | | | | | | | | | | □ YES | | | | | □ NO |
| If yes, please indicate the appropriate organism(s): | | | | | | | | | | | | | | | | History or Colonization | | | | | Active Infection |
| Methicillin-Resistant *Staphylococcus aureus* (MRSA) | | | | | | | | | | | | | | | | □ | | | | | □ |
| Vancomycin-Resistant *Enterococcus* (VRE) | | | | | | | | | | | | | | | | □ | | | | | □ |
| *Clostridioides difficile* | | | | | | | | | | | | | | | | □ | | | | | □ |
| Carbapenem-Resistant *Acinetobacter baumannii* (CRAB) | | | | | | | | | | | | | | | | □ | | | | | □ |
| Extended-Spectrum Beta-Lactamase producing Enterobacterales (ESBL) | | | | | | | | | | | | | | | | □ | | | | | □ |
| Carbapenem-Resistant Enterobacterales (CRE) | | | | | | | | | | | | | | | | □ | | | | | □ |
| Carbapenem-Resistant *Pseudomonas aeruginosa* (CRPA) | | | | | | | | | | | | | | | | □ | | | | | □ |
| *Candida auris* | | | | | | | | | | | | | | | | □ | | | | | □ |
| SARS-COV-2 (COVID-19) | | | | | | | | | | | | | | | | □ | | | | | □ |
| Influenza | | | | | | | | | | | | | | | | □ | | | | | □ |
| Chickenpox/Shingles | | | | | | | | | | | | | | | | □ | | | | | □ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | □ | | | | | □ |
| Does the patient/resident have any pending culture results? | | | | | | | | | | | | | | | | □ YES | | | | | □ NO |
| **Clinical Status** | | | | | | | | | | | | | | | | | | | | | |
| Does the patient/resident currently have signs and/or symptoms of possible infection? | | | | | | | | | | | | | | | | □ YES | | | | | □ NO |
| If yes, please indicate which of the following signs and/or symptoms: | | | | | | | | | | | | | | | | | | | | | |
| □ | Fever | | □ | Vomiting/Abdominal Pain | | | □ | | Cough/Respiratory Secretions | | | | | | □ | | | Shortness of Breath/Chest Pain | | | |
| □ | Urinary Incontinence/Dysuria | | □ | Acute Diarrhea/Stool Incontinence | | | □ | | Rash (e.g., vesicular) | | | | | | □ | | | Draining Wound | | | |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **Infection Risk Factors** | | | | | | | | | | | | | | | | | | | | | |
| Does the patient/resident have any existing risk factors for infection? | | | | | | | | | | | | | | | | □ YES | | | | | □ NO |
| If yes, please indication which of the following risk factors: | | | | | | | | | | | | | | | | | | | | | |
| □ | Central Line/PICC | | □ | Hemodialysis Catheter | | | □ | | Urinary Catheter | | | | | | □ | | | Suprapubic Catheter | | | |
| □ | Ventilator/Intubated | | □ | Tracheostomy | | | □ | | Nasogastric/PEG Tube | | | | | | □ | | | Colostomy/Fecal Management System | | | |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **Antibiotic Course** | | | | | | | | | | | | | | | | | | | | | |
| Is the patient/resident currently receiving antimicrobial therapy? | | | | | | | | | | | | | | | | | YES | | | | NO |
| Drug | | Dose | | Frequency | | Indication | | Start Date | | | | Anticipated Duration | | | | | | | | Date/Time Last Dose | |
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