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.

[Affix Patient/Resident Label Here]

Patient/Resident Information

Last Name	*First Name*	*Date of Birth*	*Medical Record/ID Number*

Sending/Transferring Facility Information

Transfer Date	*Transferring Facility Name, City/State*

Transferring Facility Point of Contact and Phone Number

Receiving Facility Name, Point of Contact and Phone Number

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 (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