INFECTION CONTROL TRANSFER FORM

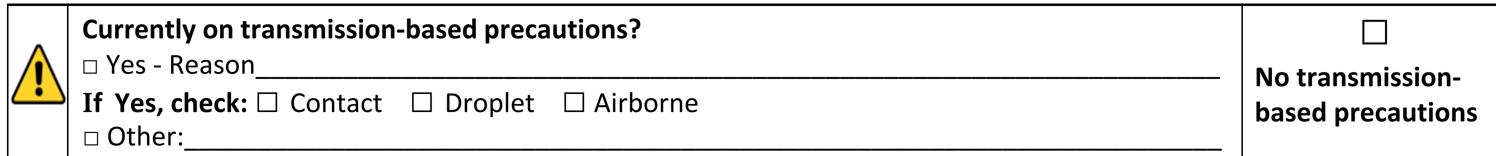
OC health CARE AGENCY

This form should be sent with the patient/resident upon transfer. It is NOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Affix any patient labels here.

Demographics

Patient/Resident *(Last Name, First Name)*:		
Date of Birth: / /	**MRN:**	**Transfer Date:** / /
Sending Facility Name:		
Receiving Facility Name:		
Receiving Facility Contact Name:	**Receiving Facility Contact Phone:**	



Currently on transmission-based precautions?

☐ Yes - Reason____

If Yes, check: ☐ Contact ☐ Droplet ☐ Airborne

☐ Other:____

☐ **No transmission-based precautions**

Organisms

Does the person have a history of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?:	History of infection/ colonization	Recent exposure or pending results
MRSA/VRE	☐	☐
Candida auris	☐	☐
CRAB/CRPA (*Acinetobacter* or *Pseudomonas* resistant to carbapenem antibiotics)	☐	☐
CRE (*E. coli*, *Klebsiella* or *Enterobacter* resistant to carbapenem antibiotics)	☐	☐
ESBL (*E. coli* or *Klebsiella* producing extended-spectrum beta lactamase)	☐	☐
C. difficile	☐	☐
Other (e.g. lice, scabies, disseminated shingles, norovirus, flu, TB, etc): ________________________________ ________________________________	☐	☐
Additional information if known:	☐ **NO history of infection/colonization**	☐ **NO recent exposure or pending results**

Symptoms

Check any that currently apply:

☐ Cough/uncontrolled respiratory secretions	☐ Acute diarrhea	☐ Other uncontained body fluid/drainage
☐ Incontinent of urine	☐ Vomiting	☐ Concerning rash (e.g.; vesicular)
☐ Incontinent of stool	☐ Draining/open wounds	☐ None applicable

Please send documentation related to medical history, e.g culture and antimicrobial susceptibility test results with applicable dates.

Person completing form/Title:____

Contact phone:____

Date:____