Indiana Department of Health

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Governor

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State Health Commissioner

Inter-Facility Infection Control Transfer Form

This inter-facility infection control patient transfer form can assist in fostering communication during transitions of care for patients infected with MDROs, COVID-19, etc. The discharging facility should complete this transfer from and sign at the bottom after all fields are completed. Attach copies of pertinent records and latest laboratory reports to send with the patient to the receiving facility. This form has been adapted from the Centers for Disease Control and Prevention (CDC).

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 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	Contact Name	Phone	E-mail
Transferring RN/Unit			
Transferring physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history Colonization Active infection of positive culture of a multidrug-resistant organism (MDRO) or other or history potentially transmissible infectious organism?	Colonization or History (*Check if Yes*)	Active Infection on Treatment (*Check if Yes*)
Methicillin-resistant *Staphylococcus aureus* (MRSA)	☐Yes	☐Yes
Vancomycin-resistant *Enterococcus* (VRE)	☐Yes	☐Yes
Clostridioides difficile	☐Yes	☐Yes
Acinetobacter, multidrug-resistant	☐Yes	☐Yes
Enterobacteriaceae (e.g., f. *coli, Klebsiella, Proteus)* producing- Yes Extended Spectrum Beta-Lactamase (ESBL)	☐Yes	☐Yes
Carbapenem-resistant Enterobacteriaceae (CRE)	☐Yes	☐Yes
Pseudomonas aeruginosa, multidrug-resistant	☐Yes	☐Yes
Candida auris	☐Yes	☐Yes
COVID-19 Choose a Test Type: ☐PCR ☐POC Antigen	☐Yes	☐Yes
Other, specify (e.g., scabies, norovirus, influenza):	☐Yes	☐Yes

Does the person* currently have any of the following? (☐Check here if none apply)

☐ Cough or requires suctioning	☐ Hemodialysis catheter
☐ Diarrhea	☐ Urinary catheter (Approx. date inserted
☐ Vomiting	☐ Suprapubic catheter
☐ Incontinent of urine or stool	☐ Percutaneous gastrostomy tube
☐ Open wounds or wounds requiring dressing change	☐ Tracheostomy
☐ Central line/PICC Approx. date inserted:	
☐ Drainage (source):	

Is the person* currently in Transmission-Based Precautions? ☐ NO ☐ YES

Type of Precautions (check all that apply): ☐ Contact ☐ Droplet ☐Airborne

☐Other:

☐Reason for Precautions:

Vaccine	Date administered (If known)	Lot and Brand (If known)	Year administered (If exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				☐ Yes ☐ No
Pneumococcal (PPSV23)				☐ Yes ☐ No
Pneumococcal (PCV13)				☐ Yes ☐ No
COVID-19				☐ Yes ☐ No
Other:				☐ Yes ☐ No

*Refers to patient or resident depending on transferring facility

Required PPE

☐ 

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Name of staff completing form (print):

Signature:

If information communicated prior to transfer:

Name of individual at receiving facility:

Phone of individual at receiving facility: