

# Hospital Quality Improvement

## COLLABORATORS:

Alabama Hospital Association  
Alliant Quality  
Comagine Health  
Georgia Hospital Association  
KFMC Health Improvement Partners  
Konza

# Inter-Facility Infection Control Transfer Form

Best practice recommendation: Complete prior to transfer to accepting facility. If sent with initial referral, update when transfer occurs.  
Attach copies of most recent 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	Contact Name	Phone	Email
Transferring RN/Unit			
Transferring Physician			
Case Manager / Admin / SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonization or History (Check if YES)	Active Infection on Treatment (Check if YES)
Methicillin-resistant Staphylococcus aureus (MRSA)	<input type="checkbox"/>	<input type="checkbox"/>
Vancomycin-resistant Enterococcus (VRE)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Clostridioides difficile</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Acinetobacter</i> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
Enterobacteriaceae (e.g., <i>E. coli</i> , <i>Klebsiella</i> , <i>Proteus</i> ) producing- Extended Spectrum Beta-Lactamase (ESBL)	<input type="checkbox"/>	<input type="checkbox"/>
Carbapenem-resistant Enterobacteriaceae (CRE)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Pseudomonas aeruginosa</i> , multidrug-resistant	<input type="checkbox"/>	<input type="checkbox"/>
<i>Candida auris</i>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify (e.g., lice, scabies, norovirus, influenza, COVID-19): _____		
If COVID-19, please include date of diagnosis: _____		

Does the person\* currently have any of the following? Check here  if none apply

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

Is the person\* currently in Transmission-Based Precautions?  No  Yes  
 Type of Precautions (check all that apply)  Contact  Droplet  Airborne  Other: \_\_\_\_\_

Reason for Precautions: \_\_\_\_\_

Is the person\* currently on antibiotics?  No  Yes  
 List any antibiotics, current or in the previous 6 months, the person\* has been prescribed.

Antibiotic, Dose, Route, Frequency	Treatment for	Start Date	Anticipated Stop Date	Date/Time of Last Dose

Has the person\* received treatment for COVID-19?  No  Yes

Dose, Route, Frequency	Start Date	Anticipated Stop Date	Date/Time of Last Dose

Vaccine	Date Administered (If known)	Lot and Brand (If known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)			<input type="checkbox"/> Yes <input type="checkbox"/> No
COVID-19			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumococcal (PPSV23, PCV13, PCV20)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Refers to patient or resident, depending on transferring facility

Name of staff completing form (print): \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If information communicated prior to transfer:  
 Name of individual at receiving facility: \_\_\_\_\_ Phone of individual at receiving facility: \_\_\_\_\_