NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Place patient sticker here

INTER-FACILITY TRANSFER FORM

Use this form for all patient transfers between facilities. This form is not intended to be used for admission criteria. It does not replace case management communication or nurse-to-nurse report.

Facilities should designate personnel responsible for completion of this form to ensure consistent use.

Patient Name:		
DOB:	**MRN:**	**Transfer Date:**
Receiving Facility (RF):		
RF Contact Name:	**RF Contact Phone:**	
Sending Facility (SF):		
SF Contact Name:	**SF Contact Phone:**	

PRECAUTIONS

Check all applicable Isolation Precautions: ☐ Airborne ☐ Contact ☐ Droplet ☐ Standard

Personal protective equipment (PPE) recommended:


☐ Gown


☐ Mask


☐ N-95/PAPR


☐ Eye Protection


☐ Gloves

ORGANISM(S) ☐ NONE IDENTIFIED

Organism(s)	Specimen Source (e.g., sputum)	Collection Date	**Status:** active infection / colonized / history of infection / test pending
☐ **C. auris** (*Candida auris*)			
☐ **C. diff** (*Clostridioides difficile*)			
☐ **CRE** (Carbapenem-resistant Enterobacterales)			
☐ **MDR Gram Negatives** (e.g. Acinetobacter, Pseudomonas)			
☐ **MRSA** (methicillin-resistant *Staphylococcus aureus*)			
☐ **VRE** (vancomycin-resistant Enterococcus)			
☐ **Other, specify:** (e.g. COVID-19, flu, lice, norovirus, scabies, TB, VRSA, etc.)			