Please attach copies of latest culture reports with susceptibilities if available

Name/Address of Sending Facility	Sending Unit	Phone #

Sending Facility Contacts	Name	Phone	Fax #
Case Manager/Admin/SW			
Infection Prevention			

Attending Physician:	Infectious Disease Physician:

Is the patient currently in transmission based precautions (TBP)? ☐ NO ☐ YES

Type of TBP (check all that apply) ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: ________________________

Current or previous diagnosis of Sepsis? ☐ NO ☐ YES Approx date: _____ /_____ /______

Does patient currently have an infection, colonization or history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Active Infection on treatment *Check if YES*	Colonization or history *Check if YES*	Source
Methicillin-resistant Staphylococcus aureus (MRSA)			
Vancomycin-resistant Enterococcus (VRE)			
Clostridium difficile (C Diff)			
Acinetobacter, multidrug-resistant			
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL/MDRO)			
Carbapenemase resistant Enterobacteriaceae (CRE) or Pseudomonas			
Other:			

Does the patient currently have any of the following?

- ☐ Has the patient ever been diagnosed with active or latent TB? ☐ NO ☐ YES
- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Drainage (source) ___________
- ☐ Tracheostomy
- ☐ Central line/PICC/Port a Cath (Approx date inserted _____/ _____/_____) Indication: __________________
- ☐ Hemodialysis catheter/Shunt (Approx. date inserted _____/ _____/_____)
- ☐ Urinary catheter (Approx date inserted _____/ _____/ _____) Indication: __________________
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Open wounds or wounds requiring dressing change
- ☐ Surgery in the last 90 days Type ________________________ (Approx. date _____/ _____/_____) Condition of Incision: ____________________
- ☐ Chest x ray within the last 30 days (Required for ECF bed only)

Is the patient currently on antimicrobial agents? ☐ NO ☐ YES

Antimicrobial agent and dose	Treatment for:	Start Date	Anticipated Stop Date

<u>Pneumococcal Vaccine</u> Month/Year administered: _____ /_______	<u>Influenza Vaccine</u> Month/Year administered: _____/_______

Name and phone number of individual at receiving facility	Person completing form at time of transfer	Date/Time