

Place patient sticker here

# INFECTIOUS ORGANISM 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
<input type="checkbox"/> <b>C. auris</b> ( <i>Candida auris</i> )			
<input type="checkbox"/> <b>C. diff</b> ( <i>Clostridioides difficile</i> )			
<input type="checkbox"/> <b>CRE</b> (Carbapenem-resistant Enterobacterales)			
<input type="checkbox"/> <b>MDR Gram Negatives</b> (e.g. Acinetobacter, Pseudomonas)			
<input type="checkbox"/> <b>MRSA</b> (methicillin-resistant <i>Staphylococcus aureus</i> )			
<input type="checkbox"/> <b>VRE</b> (vancomycin-resistant Enterococcus)			
<input type="checkbox"/> <b>Other, specify:</b> (e.g. COVID-19, flu, lice, norovirus, scabies, TB, VRSA, etc.)			

