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 aeruginosa multidrug-resistant			
Candida auris (C. auris)			
COVID-19/ 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 ☐ Central line/PICC/Port a Cath (Approx. date inserted_____/_____/_____) Indication: _____

☐ Diarrhea ☐ Hemodialysis catheter/Shunt (Approx. date inserted_____/_____/_____)

☐ Vomiting ☐ Urinary catheter (Approx. date inserted_____/_____/_____) Indication: _____

☐ Incontinent of urine or stool ☐ Suprapubic catheter

☐ Drainage (source)_____ ☐ Percutaneous gastrostomy tube

☐ Tracheostomy ☐ 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

Pneumococcal Vaccine Month/Year administered:_____/_____	Influenza Vaccine Month/Year administered:_____/_____

COVID-19 Vaccine 1st dose___, 2nd dose___, booster ____	Other:

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