PATIENT TRANSFER: INFECTION CONTROL AND ANTIBIOTIC SUMMARY FORM

Date of Transfer: _____ Approx. Time of Transfer: _____ ☐ AM ☐ PM

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number

Name/Address of Sending Facility	Sending Unit	Sending Unit Contact Name and Phone

Patient's/Resident's Primary Physician at Sending Facility: _____

Primary Reason for Transfer: _____

Name of Receiving Facility: _____

Is the patient/resident currently on transmission-based precautions?

☐ No ☐ Yes (check all that apply):

Indication for precautions: _____

☐ Contact – gown and gloves

☐ Droplet – surgical/procedure mask

☐ Airborne – N95 or PAPR

Patient's/Resident's Infection Control History

Organism	Currently Infected or Ruling Out	Known Colonization or Prior History	Notes (optional)
Multidrug-Resistant Organisms			
MRSA	☐	☐	
VRE	☐	☐	
CRE or CP-CRE	☐	☐	
E. coli, *Klebsiella* with ESBL	☐	☐	
Acinetobacter, multidrug-resistant	☐	☐	
Candida auris	☐	☐	
Other (please specify)	☐	☐	
Highly Communicable Organisms			
C. difficile	☐	☐	
Gastroenteritis/Norovirus	☐	☐	
Influenza	☐	☐	
Tuberculosis	☐	☐	
Scabies	☐	☐	
Other (please specify):	☐	☐	

Is the patient/resident currently on antibiotics, antivirals, or antifungals? ☐ No ☐ Yes (specify below)

Antibiotic/Antiviral/Antifungal and Dose	Treatment for	Start Date	Anticipated Stop Date

ATTACH COPY OF PERTINENT CULTURE RESULTS

Printed Name of Person Completing Form	Signature	Date	If verbal report provided prior to transfer, name and phone of receiving facility contact