HEALTHCARE FACILITY TRANSFER FORM

Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

Patient Name (Last, First):		
Date of Birth:	MRN:	Transfer Date:

Receiving Facility Name (if known): _____

Contact Name (optional): _____ Contact Phone (optional): _____

Sending Facility Name: _____

Contact Name: _____ Contact Phone: _____

PRECAUTIONS

Patient currently on precautions? ☐ **Yes** ☐ **No**

If yes, check all that apply: ☐ Airborne ☐ Contact ☐ Droplet ☐ Enhanced Standard*

*Long-term care facilities may implement Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx) for patients with multidrug-resistant organisms (MDROs) or risk factors for transmission, i.e., gown and glove use for high-contact care activities; such patients may be on Contact Precautions in acute care settings.

ORGANISMS (Include copy of **lab results** with organism ID and antimicrobial susceptibilities.)

☐ **Patient is NOT known to be colonized or infected with any multidrug-resistant or other organisms requiring precautions (*skip section*)**

☐ **Patient has MDRO or other lab results requiring precautions** (record organism(s), specimen source, collection date)

☐ **Exposed to MDRO/other** (record organism(s) and last date(s) of exposure if known)

Organism	Carbapenemase (if applicable)**	Source	Date
☐ *Candida auris* (***C. auris***)			
☐ *Clostridiodes difficile* (***C. diff***)			
☐ *Acinetobacter*, multidrug-resistant (e.g., **CRAB****)			
☐ Carbapenem-resistant Enterobacterales (**CRE****)			
☐ *Pseudomonas aeruginosa,* multidrug-resistant (e.g., **CRPA****)			
☐ Extended-spectrum beta-lactamase (**ESBL**)-producer			
☐ Methicillin-resistant *Staphylococcus aureus* (**MRSA**)			
☐ Vancomycin-resistant *Enterococcus* (**VRE**)			
☐ No organism identified (e.g., molecular screening test**)			
☐ **Other, specify**: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis)			

**Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known

Affix patient labels here.

CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

☐ **Yes** ☐ **No**

If yes, check all that currently apply:

☐ Cough/uncontrolled respiratory secretions
☐ Vomiting
☐ Acute diarrhea or incontinent stool
☐ Incontinent of urine
☐ Total dependence for activities of daily living
☐ Rash consistent with an infectious process (e.g., vesicular)
☐ Draining wounds §
☐ Other uncontained bodily fluid/drainage

ANTIBIOTICS/ANTIFUNGALS

Patient is currently on antibiotics/systemic antifungals?

☐ **Yes** ☐ **No**

If yes, specify:

Antibiotic/Antifungal	Dose	Frequency	Indication	Start Date	Stop Date

DEVICES §

Patient currently has any of the following devices?

☐ **Yes** ☐ **No**

If yes, check all that currently apply:

☐ Central line/PICC, Date inserted:
☐ Hemodialysis catheter
☐ Fecal management system
☐ Percutaneous gastrostomy feeding tube
☐ Wound VAC
☐ Tracheostomy
☐ Urinary catheter, Date inserted:
☐ Suprapubic catheter
☐ Mechanical ventilation

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)

☐ **Yes (specify below)** ☐ **No**

Vaccine	Date(s)

§ Risk factors for MDRO transmission per Enhanced Standard Precautions (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx)