***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 ☐ 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: ____/_____ |
|---|---|

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