

Multidrug-Resistant Organism: Interfacility Transfer Form

TRANSFERRING FACILITY: Please send this completed form with the EMS transporters

RECEIVING FACILITY: Please provide completed form to your facility's Infection Prevention & Control Program

➔ Use this form when transferring a hospitalized patient or long term care facility resident who is either *infected* or *colonized* with a multidrug-resistant organism (MDRO).

MDRO examples: methicillin-resistant *Staphylococcus aureus* (**MRSA**), vancomycin-resistant Enterococci (**VRE**), *Clostridium difficile* (**Cdiff**), carbapenem-resistant *Enterobacteriaceae* (**CRE**), and other multidrug-resistant gram negative rods (**MDR-GNR**). CRE include *E. coli*, *Enterobacter spp.*, and *Klebsiella spp.* organisms which are resistant to carbapenem antibiotics.

Patient/Resident Name (Last, First, MI) _____	DOB ____/____/____
Transferring facility name: _____	
Transferring facility contact: _____ Phone _____	
Receiving facility name/city/state: _____	
MDRO Information: <input type="checkbox"/> No history of MDROs (past 2 years) <input type="checkbox"/> 1 MDRO <input type="checkbox"/> >1 MDRO (provide information in comments)	
Organism 1 Name: <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C. difficile <input type="checkbox"/> CRE (list species) _____	
<input type="checkbox"/> Others (list names) _____	
Date (month/year) of last positive culture: _____	
What is the infection status: <input type="checkbox"/> Recent Active Infection <input type="checkbox"/> Colonization only <input type="checkbox"/> Unknown	
Location of infection/colonization (i.e., body site): _____	
Is the patient/resident currently on antibiotics for this infection?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
The patient/resident is currently placed on transmission-based precautions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, type of precautions: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Isolation <input type="checkbox"/> Airborne <input type="checkbox"/> Other _____	
ADDITIONAL COMMENTS: Lines? Foleys? Devices? 	

