

**Infection Prevention and Control (IPC) Transfer Form**

**Sending HCF/Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Receiving HCF/Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MRN/FIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Transfer Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Precautions**

Patient currently on Precautions? *Yes* No

If yes, circle all that apply: **Airborne Contact Droplet Enteric Enhanced Barrier Precautions**

 **Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient has: [ ]  wound(s) [ ]  Indwelling device(s)

**Organisms**

 Patient is NOT known to be colonized or infected with any multidrug-resistant or other organisms requiring precautions - examples listed in the table below (*If this box is checked, then* *skip the next section*)

 **Patient has MDRO *(multiple drug resistant organism)* or has been exposed to MDRO**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Organism** | **History of:** **-OR-** | **Recent** **Result:** | **If recent, please specify:*** **Source and**
* **Date Collected**
 | For either history of or recent:**Resistant Mechanism** (KPC, NDM, IMP, OXA, VIM, etc.) |
| *Candida auris (C. auris)*  |  |  |  |  |
| *Clostridiodes difficile (C.diff)* |  |  |  |  |
| *Acinetobacter, multidrug resistant* |  |  |  |  |
| *Carbapenem-resistant**Enterobacterales (CRE)* |  |  |  |  |
| *Pseudomonas aeruginosa (multidrug resistant)* |  |  |  |  |
|  *Extended spectrum beta lactamase (ESBL) producer* |  |  |  |  |
|  *Methicillin-resistant Staphylococcus aureus (MRSA)* |  |  |  |  |
|  *Vancomycin-resistant Enterococcus (VRE)* |  |  |  |  |

 **Patient Exposed to other disease/infection**

|  |  |  |  |
| --- | --- | --- | --- |
| *SARS-CoV-2 (COVID 19)* |  |  |  |
| *Influenza A or B* |  |  |  |
| *Lice* |  |  |  |
| *Scabies* |  |  |  |
| *Norovirus* |  |  |  |
| *Tuberculosis* |  |  |  |
| *Other:*  |  |  |  |

 **Patient Unit/Facility in Current Outbreak Status**

|  |
| --- |
| *Disease:*  |

Signature Title Phone Date/Time