***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:

Is the patient currently in transmission based precautions (TBP)? NO YES

Infectious Disease Physician:

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-intermediate Staphylococcus aureus (VISA) and/or Vancomycin-resistant Staphylococcus aureus (VRSA) Infections |  |  |  |
| Vancomycin-resistant Enterococcus (VRE) |  |  |  |
| Clostridium difficile (C Diff) |  |  |  |
| Acinetobacter or Pseudomonas, multidrug-resistant |  |  |  |
| E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL/MDRO) |  |  |  |
| Carbapenem resistant Enterobacteriaceae (CRE)  |  |  |  |
| 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 / / )

Incontinent of urine or stool Suprapubic catheter

Indication:

Drainage (source) Percutaneous gastrostomy tube

Influenza Vaccine Month/Year administered: /

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: /

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

