

# UTAH INFECTION CONTROL TRANSFER FORM

(Discharging Facility to complete form and communicate information to Receiving Facility)

<b>Demographics</b>	<b>Patient/Resident</b>		<b>Date of Birth:</b>	<b>MRN:</b>	<b>Discharge Date:</b>
	<i>Last Name</i>	<i>First Name</i>			
	<b>Sending Facility Name:</b>		<b>Contact Name:</b>		<b>Contact Phone:</b>
	<b>Receiving Facility Name:</b>				

<b>Precautions</b>	<b>Currently in Isolation Precautions?</b> <input type="checkbox"/> Yes		<input type="checkbox"/> No Isolation Precautions
	If Yes check: <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> Other: _____		

<b>Organisms</b>	<b>Did or does have (send documentation):</b>	<b>Current Infection, History, or Ruling Out*</b>	<input type="checkbox"/> No Known MDRO or Communicable Diseases
	<b>Multiple Drug Resistant Organism (MDRO):</b>	<input type="checkbox"/> Yes	
	MRSA	<input type="checkbox"/>	
	VRE	<input type="checkbox"/>	
	Acinetobacter not susceptible to carbapenems	<input type="checkbox"/>	
	E. coli or Klebsiella not susceptible to carbapenems	<input type="checkbox"/>	
	<b>Significant communicable disease:</b>	<input type="checkbox"/> Yes	
	C. diff	<input type="checkbox"/>	
	Other <sup>±</sup> : _____ <small>±e.g.; lice, scabies, disseminated shingles, norovirus, flu, TB, etc.</small>	<input type="checkbox"/> (current or ruling out)	
<b>*Additional info if known:</b>			

<b>Symptoms</b>	<b>Check yes to any that <u>currently</u> apply*):</b>		<input type="checkbox"/> No Symptoms or PPE not required as "contained"
	<input type="checkbox"/> Cough/uncontrolled respiratory secretions	<input type="checkbox"/> Acute diarrhea or incontinent of stool	
	<input type="checkbox"/> Incontinent of urine	<input type="checkbox"/> Draining wounds	
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Other uncontained body fluid/drainage	
		<input type="checkbox"/> Concerning rash (e.g.; vesicular)	
<b>*NOTE: Appropriate PPE required ONLY if incontinent/drainage/rash NOT contained</b>			

<b>Required PPE</b>	<b>ISOLATION PRECAUTIONS</b>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <input type="checkbox"/> </div> <div style="text-align: center;">  <input type="checkbox"/> </div> <div style="text-align: center;">  <input type="checkbox"/> </div> </div> <p style="text-align: center;">CHECK IF INDICATED</p>	<p>Answers to sections above</p> <p><b>ANY YES:</b> Check Required PPE</p> <p><b>ALL NO:</b> Just sign form</p>
			<p>Person completing form: _____</p> <p>Role: _____ Date: ____/____/____</p> <p style="font-size: small;">Version 1.6 4/23/2014 – e.version</p>