West Virginia Department of HEALTH

Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to the accepting facility with information communicated prior to or with transfer.
Please attach copies of latest culture reports with susceptibilities if available.

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number
		/ /	

Name/Address of Sending Facility	Sending Unit	Sending Facility phone

Sending Facility Contacts	NAME	PHONE	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient/resident currently in isolation? □ NO □ YES
Type of Isolation (check all that apply) □ Contact □ Droplet □ Airborne □ Enhanced Barrier Precautions □ Other: _________
Does the patient/resident have pending cultures? □ NO □ YES
PPE (personal protective equipment) needed (check all that apply):

□ **Gown**

□ **Gloves**

□ **Eye Protection**

□ **Mask**

□**N-95/PAPR**

Does patient currently have an infection, colonization OR a history of positive culture ofa multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or history** *If yes, provide date of positive lab result*	**Active infection on Treatment** *If yes, provide date of positive lab result*
Candida auris		
Clostridioides difficile (C. diff)		
Carbapenem-resistant Acinetobacter baumanii (CRAB)		
Carbapenem-resistant Enterobacterales (CRE)		
Carbapenem-resistant Pseudomonas aeruginosa (CRPA)		
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)		
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Other:		

Does the patient/resident currently have any of the following?

- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Open wounds or wounds requiring dressing change
- ☐ tube Drainage (source)______________________
- ☐ Central line/PICC (Approx. date inserted ___/___/_____)
- ☐ Hemodialysis catheter
- ☐ Urinary catheter (Approx. date inserted ___/___/_____)
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy
- ☐ Tracheostomy

Printed Name of Person Responsible for Transfer	**Signature**	**Date and Time**	**Name and phone of individual at receiving facility/ transportation/ EMS**

Please contact the Healthcare-Associated Infections, Antimicrobial Resistance (HAI/AR) program with any questions.
Email: OEPSMDRO@wv.gov Phone: (304) 558-5358 ex.2.