INFECTION CONTROL SOCIETY OF SOUTHERN AFRICA

Federation of Infectious Diseases Societies of Southern Africa

Inter-facility Infection Prevention & Control Transfer Form (v2)

This form must be completed for transfer to accepting facility with information communicated prior to or on transfer

NNB: Please attach copies of latest culture reports with susceptibilities if available

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
Infection Prevention& Control			
Case Manager / Admin / other			

Receiving Facility Contacts	NAME	PHONE	E-mail
Infection Prevention& Control			
Case Manager / Admin / other			

Is the patient currently in isolation? ☐ **NO** ☐ **YES**
Type of Isolation (tick all that apply) ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Other:** _____

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or history** ***Check if YES***	**Active infection on Treatment** ***Check if YES***
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter/Pseudomonas MDR or XDR or PAN (circle one)		
E coli, Klebsiella, Proteus etc. with Extended Spectrum B-Lactamase (ESBL)		
Carbapenemase-producing Enterobacteriaceae (CPE)		
Pulmonary or Laryngeal Tuberculosis Sensitive / MDR / XDR (circle one)		
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
☐ Drainage (source) _____
☐ Central line / PICC (Approx. date inserted __/__/____)
☐ Hemodialysis catheter
☐ Urinary catheter (Approx. date inserted __/__/_____)
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Tracheostomy

Is the patient/resident currently on antibiotics ☐ **NO** ☐ **YES**

Antibiotic and dose	**Treatment for:**	**Start date**	**Anticipated stop date**

Printed Name of Person completing form	**Signature**	**Date**	**If information communicated prior to transfer: Date communicated & Name of individual at receiving facility**