Inter-Facility Infection Control Communication Worksheet

This form is used to ensure relevant infection control information is accurately and completely communicated between transferring and receiving facilities. Attach culture reports & susceptibilities when available; call results to receiving facility if received after transfer.

Sending Facility:

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

Sending Facility Contacts	Name	Phone	E-mail
Case Manager/Admin/SW			
Infection Preventionist			

Was the patient in isolation or transmission-based precautions? ☐ NO ☐ YES
Type of isolation or precautions (check all that apply): ☐ Contact ☐ Droplet ☐ Airborne ☐ Other
Explain "Other" entry: _____

Does patient/resident currently have an infection, colonization, or a history of positive culture for a MDRO or other epidemiologically significant organism?	Active infection on Treatment (YES or NO)	Colonization or history (YES or NO)
Methicillin-resistant *Staphylococcus aureus* (MRSA)		
Vancomycin-resistant *Enterococcus* (VRE)		
Clostridium difficile		
Acinetobacter, multidrug resistant		
E. coli, Klebsiella, Proteus, or other organism(s) with ESBL		
Carbapenemase-resistant Enterobacteriaceae (CRE)		
Other:		

Does patient/resident currently have any of the following (check all that apply)?

- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinence (bowel or bladder)
- ☐ Open wounds or required dressing changes
- ☐ Drainage (source):_____
- ☐ Central line/PICC (date inserted:____/____/_____)
- ☐ Hemodialysis catheter
- ☐ Urinary catheter (date inserted:____/____/_____)
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Tracheostomy

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

Antibiotic and dose	Indicated for:	Start date	Scheduled stop date

Vaccine	Date administered (enter year if date unknown)	Lot & Brand (if known)	Does patient self report receiving vaccine? YES	NO
Influenza (seasonal)				
Pneumococcal				
Shingles				
Other:				

Person completing this report (Print Name)	Date completed	Contact telephone number

This material was developed by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii and the U.S. Pacific Territories of Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Contents presented do not necessarily reflect CMS policy. 11SOW-MPQHF-WY-C3-15-10