

South Dakota Inter-facility Infection Control Transfer Form

Please use this form when transferring a patient with Carbapenem-resistant Enterobacteriaceae (CRE)

**This form must be filled out for transfer to 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 No.
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 currently in isolation? No Yes
 Type of isolation (check 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?	Include Colonization or history <i>Check if YES</i>
Carbapenem-resistant Enterobacteriaceae (CRE)	
Clostridium difficile (Cdiff)	
Methicillin-resistant Staphylococcus aureus (MRSA)	
Vancomycin-resistant Entrococci (VRE)	
Acinetobacter (Multi-drug resistant)	
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)	
Pseudomonas aeruginosa (CRE ESBL)	

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

- | | |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Cough or requires suctioning | <input type="checkbox"/> Central line/PICC (Approx. date inserted ___/___/___) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemodialysis catheter |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary catheter (Approx. date inserted ___/___/___) |
| <input type="checkbox"/> Incontinent of urine or stool | <input type="checkbox"/> Suprapubic catheter |
| <input type="checkbox"/> Open wounds or wounds requiring dressing change | <input type="checkbox"/> Percutaneous gastrostomy tube |
| <input type="checkbox"/> Drainage (source) _____ | <input type="checkbox"/> Tracheostomy |

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

For questions, please contact: Angela Jackley, RN Healthcare Associated Infection Coordinator, South Dakota Department of Health, Office of Disease Prevention 605-773-5348 or Angela.Jackley@state.sd.us. CRE Toolkit: <http://www.cdc.gov/hai/organisms/cre/cre-toolkit/index.html>

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