FOUNDATION HEALTH PARTNERS

# Denali Center Infection Control Transfer Form

Revised 3/20/2017

*Resident Sticker*

*Last Name* *

*First Name* *

*DOB* *

## Transfer Facility Information

*Transferring Facility Name*

*Admission date (actual or estimate)*

*Admission Reason*

## Communicable Disease History

*Is resident currently on Isolation Precautions?* ○ Yes ○ No ○ Unknown *If Yes, Type of Isolation* Select...

*Indicate Communicable Disease History Below. Please include the following if history is present: Status i.e. Active, colonized (or Latent for TB), treated, last positive culture date, and culture location i.e. wound, urine, nasal, sputum.*

*History of MRSA?* ○ Yes ○ No ○ Unknown
*MRSA Status?* Select... *Last Positive Culture?*
*Culture Location?* Select...

*History of VRE?* ○ Yes ○ No ○ Unknown
*VRE Status?* Select... *Last Positive Culture?*
*Culture Location?* Select...

*History of ESBL?* ○ Yes ○ No ○ Unknown
*ESBL Status?* Select... *Last Positive Culture?*
*Culture Location?* Select...

*History of CRE?* ○ Yes ○ No ○ Unknown
*CRE Status?* Select... *Last Positive Culture?*
*Culture Location?* Select...

*History of MDRO other?* ○ Yes ○ No ○ Unknown
*MDRO other Status?* Select... *Last Positive Culture?*
*Culture Location?* Select...

*History of C-diff?* ○ Yes ○ No ○ Unknown
*C-diff Status?* Select... *Last Positive Culture?*
*Culture Location?* Stool

*History of TB?* ○ Yes ○ No ○ Unknown
*TB Status?* Select... *Last Chest X-ray?*
*X-ray Results?*

*History of Shingles?* ○ Yes ○ No ○ Unknown

*History of Herpes?* ○ Yes ○ No ○ Unknown

## Signs and Symptoms

*Please indicate if the Resident has any of the following Signs or Symptoms at time of transfer*

| | | | |
|---|---|---|---|
| *Cough/uncontrolled respiratory secretions?* | ◯ Yes ◯ No | *Incontinent of urine?* | ◯ Yes ◯ No |
| *Draining wounds?* | ◯ Yes ◯ No | *Other uncontained body fluid/drain?* | ◯ Yes ◯ No |
| *Vomiting?* | ◯ Yes ◯ No | *Acute diarrhea or incontinent of stool?* | ◯ Yes ◯ No |
| *Concerning rash (i.e. vesicular)?* | ◯ Yes ◯ No | *Significant, unplanned weight loss (≥5%)?* | ◯ Yes ◯ No |

## Devices

*Please indicate whether the Resident ahs any of the following devices at time of transfer*

| | | | |
|---|---|---|---|
| *On Ventilator?* | ◯ Yes ◯ No | *Tracheostomy?* | ◯ Yes ◯ No |
| *Urinary Catheter?* | ◯ Yes ◯ No | *Dialysis Shunt/Fistula?* | ◯ Yes ◯ No |
| *Peg/J Tube?* | ◯ Yes ◯ No | *Vascular access device (PICC, PORT, PIC)?* | ◯ Yes ◯ No |

## Vaccine History

*Please enter Resident targeted Vaccination data from their stay at your facility*

| | | | |
|---|---|---|---|
| *Did the Resident Receive an Influenza Vaccine?* | ◯ Yes ◯ No | *If Yes, Date of Vaccination?* | |
| | | *If No, Last known date of vaccine administration?* | |
| *Did the Resident Receive a Pneumococcal (PPSV23) Vaccine?* | ◯ Yes ◯ No | *If Yes, Date of Vaccination?* | |
| | | *If No, Last known date of vaccine administration?* | |
| *Did the Resident Receive a Pneumococcal (PCV13) Vaccine?* | ◯ Yes ◯ No | *If Yes, Date of Vaccination?* | |
| | | *If No, Last known date of vaccine administration?* | |
| *Did the Resident Receive a Zoster Vaccine?* | ◯ Yes ◯ No | *If Yes, Date of Vaccination?* | |
| | | *If No, Last known date of vaccine administration?* | |

Signature Date/Time