HAWAII STATE DEPARTMENT OF HEALTH

STATE OF HAWAII
HEALTHCARE FACILITY TRANSFER FORM

Please use this form for ALL transfers to admitting facility.
This form is NOT meant to be used as criteria for admission.

Place patient label here.

Patient Name *(Last, First):*		
Date of Birth:	**MRN:**	**Transfer Date:**
Receiving Facility Name:		

⚠	**Currently in Isolation Precautions?** ☐ **Yes** If Yes, check: ☐ Contact ☐ Droplet ☐ Airborne Check all PPE (personal protective equipment) to be considered:  ☐ ☐ ☐	☐ **No** isolation precautions

Organisms	**Does the patient have any MDROs (multi-drug resistant organisms) or other lab results for which the patient should be in isolation?** Please include any infection, colonization, history, or "rule-out" communicable diseases.	Check **Yes** for MDRO or communicable disease & include **date** of specimen collection, if known.	☐ **No** known MDRO or communicable diseases
	C. difficile	☐ Date:	
	CRE (Carbapenem- resistant *Enterobacteriaceae* such as: *Klebsiella*, *Enterobacter* or *E. coli*)	☐ Date:	
	MDR gram negatives *(such as: Acinetobacter, Pseudomonas, etc.)*	☐ Date:	
	ESBL (extended-spectrum beta lactam resistant such as: *E. coli, Klebsiella*)	☐ Date:	
	VRE (vancomycin-resistant *Enterococcus*)	☐ Date:	
	MRSA (methicillin-resistant *Staphylococcus aureus*)	☐ Date:	
	Other: _____ Such as: lice, scabies, disseminated shingles, norovirus, flu, TB, etc.	☐ Date:	

Please include **lab results** with antimicrobial susceptibilities, **medication documentation** with antibiotic therapy end dates, and any additional info.

CONTACT INFORMATION

Sending Facility Name:	
Contact Name:	**Contact Phone:**

Contact Signature: _____ Date: _____

Available at http://health.hawaii.gov/docd/for-healthcare-providers/healthcare-associated-infections/antimicrobial-resistance/

Adapted from the Los Angeles County Department of Public Health.