NC DPH INTERFACILITY TRANSFER FORM INSTRUCTIONS

General Instructions

Purpose: In an effort to reduce the transmission of multidrug-resistant organisms (MDROs) within and between healthcare facilities as well as improve the quality of life, care, and services in healthcare facilities; optimize resident and patient safety; and reflect current professional standards, the North Carolina Division of Public Health (NC DPH) encourages healthcare facilities to utilize a standard, interfacility transfer form when transferring residents and patients.

How to use this form: The form is to be completed for all individuals who are to be transferred from one healthcare setting to another. Healthcare settings include but are not limited to inpatient and outpatient locations, hospitals, long-term care facilities, skilled nursing facilities, assisted living facilities, etc. In instances where frequent transfer is necessary between healthcare settings (e.g. dialysis appointments, wound care appointments, etc.), this form may be provided to the receiving healthcare facility or provider for the initial visit and kept on file for subsequent appointments. A new form should be provided if information contained on the initial form changes (e.g. patient is diagnosed with a MDRO, undergoes a procedure, or has a new line/tube). In instances where a patient is out of the transferring facility for less than 24 hours before returning to the original facility (e.g. visit to the Emergency Room), a new interfacility transfer form need not be completed by the original receiving facility for transfer back to the original transferring facility. Rather, any updates can be incorporated onto the originally provided interfacility transfer form.

A transferring facility representative should fill out all information on this form unless otherwise indicated. If using the fillable PDF version of this form, all information entered onto page 1 will automatically fill onto page 2 to provide an additional copy of the form to the receiving facility and for reference for transport services. Otherwise, fill out page 1 and make 1 additional copy for the receiving facility and mark the appropriate check box at the bottom of each page.

To use the fillable PDF version, a PDF viewer, such as Adobe Acrobat Reader DC must be installed. When using a PDF viewer, the form can be filled and saved locally either to continue filling later or for record-keeping purposes. Using an online PDF viewer, such as Microsoft Edge, will not allow you to save completed forms. Adobe Acrobat Reader DC can be downloaded for free from: https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html?promoid=C4SZ2XDR&mv=other .

The page with "TRANSFERRING FACILITY COPY" marked (page 1) should remain in the medical record for the individual at the transferring facility. Page 2 should be given to transport services at the time of transfer by a transferring facility representative. It is important that transport services have access to the interfacility transport form. Page 2 should be given to the receiving facility at the time of transfer by a transport services representative. This page should remain in the medical record for the individual at the receiving facility.

Information contained on this form, especially information related to isolation precautions/ required personal protective equipment (PPE), should be communicated verbally to transport services and the receiving facility prior to transfer when possible. Provision of the form serves as written communication of the same information to these entities.

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Field Level Instructions

Fields marked with an asterisk (*) are required fields. All fields should be completed by the transferring facility unless otherwise specified.

Transferring facility contact information: All information is required unless otherwise indicated.

- Transferring Facility Name* – Name of facility where individual currently or most recently resides or receives care
- Transferring Facility Address* – Address of facility where individual currently or most recently resides or receives care
- Transferring Facility Phone Number* – Phone number of facility where individual currently or most recently resides or receives care
- Transferring Facility Fax Number – Fax number of facility where individual currently or most recently resides or receives care

Transfer information: All information is required unless otherwise indicated.

- Transferred to* – Name of facility at which individual will receive care
- Reason for transfer* – Description of reason or circumstances for the transfer of the individual to another healthcare setting
- Transfer date/time* – Date on which the transfer occurred in MM/DD/YY format and time at which the individual was transferred or is expected to be transferred from the transferring facility in HH:MM AM/PM format
- Attending physician at transferring facility* – Name and title of attending physician at the facility where individual currently or most recently resides or receives care
- Phone* – Direct phone number of attending physician at transferring facility; this should not be the operator or call service

Patient/resident demographics and vital signs: Provide the requested information on the individual being transferred. Transport services or a representative at the receiving facility may also take and record vital signs (date taken, time taken, BP, P, R, T(F), O2 SAT)

- Date/time taken – Date (MM/DD/YY) and time (HH:HH AM/PM) at which individual's vital signs were taken, preferably as close to the time of transfer as possible.
- Last Name* – Individual's last name
- First Name* – Individual's first name
- DOB* – Individual's date of birth in MM/DD/YYYY format
- MRN – Individual's medical record number at the facility where the individual currently or most recently resides or receives care
- BP* – Individual's blood pressure in mm Hg
- P* – Individual's pulse in beats per minute
- R* – Individual's respiratory rate is breaths per minute
- T(F)* – Individual's oral temperature in degrees Fahrenheit
- O_2 SAT* – Individual's oxygen saturation in percent (%)
- HT(in) – Individual's height in inches
- WT(lb) – Individual's weight in pounds
- Diabetic? – Indicate whether or not the person is diabetic, "Y" for "Yes" or "N" for "No."
- Glucose – Individual's glucose level in mg/dL

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- Language – Individual's primary language; indicate "English" or "Other" and if "Other," specify the individual's primary language in the space provided.
- Mental status* – Indicate if individual is alert and/or oriented and/or some other mental status. If "Other" mental status applies, specify in the space provided.
- Allergies* – If the individual has no allergies, indicate "None." If the individual has allergies, indicate "Yes" and specify in the space provided.
- Pain – Indicate the individual's pain level on a scale of 0 (no pain) to 10 (worst pain possible) in the space provided. Specify the site of the pain in the space provided.
- At risk alerts* – If the individual does not have any risk alerts, indicate "None." Otherwise, indicate any and all risk alerts that apply to the individual. If a specific risk alert is not listed, indicate "Other," and specify in the space provided.
- Advanced directives* – Indicate any and all advanced directives that apply to the individual. If individual has a proxy, specify proxy name and phone number in the space provided.

Current isolation precautions/required PPE*: All information is required unless otherwise indicated.

- Isolation precautions* – Indicate "No" if the individual is not currently on isolation precautions for any communicable disease or condition. Indicate "Yes" and specify the type of isolation precaution (Contact, Droplet, and/or Airborne) if the individual is currently on isolation precautions for any communicable disease or condition.
- Required personal protective equipment (PPE) – Indicate the PPE required (gloves, gown, and/or mask) required during direct care of the individual based on the current isolation precautions. PPE is required if the patient is on isolation precautions.

Note: Descriptions of appropriate precautions and personal protective equipment (PPE) can be found at https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html.

Organisms/infections*: All information is required unless otherwise indicated. If the individual has no current infection(s), history of infection, or pending culture result for the listed organisms or some other organism, indicate "None." Otherwise, indicate "Yes" and specify for each organism listed whether the infection is current, the individual has a history of infection or colonization, and/or a diagnostic test is pending to determine infection status. For each status that applies, specify the date of diagnosis (current infection), date of last positive diagnostic/screening test (history or colonization), and/or specimen collection date (pending result) in MM/DD/YY format.

Current or recent (last 7 days) symptoms: If the individual does not have any current or recent (last 7 days) symptoms, indicate "None." Otherwise, indicate "Yes" and specify any and all symptoms that the individual currently has or has had in the past 7 days. If a specific symptom is not listed, indicate "Other," and specify in the space provided.

Sensory status and activities of daily living*:

- Vision – Indicate whether vision is "Good," "Poor," or if the individual is "Blind." If "Blind," specify right eye ("R"), left eye ("L"), or both eyes ("Both").
- Hearing – Indicate whether hearing is "Good," "Poor," or if the individual is "Deaf." If "Deaf" specify right ear ("R"), left ear ("L"), or both ears ("Both").
- Speech – Indicate whether speech is "Good," "Difficult," or whether individual has "Aphasia."
- Ambulate – Indicate whether the individual is able to ambulate by himself/herself ("Self"), with assistance ("Assist"), or if individual is unable to ambulate ("Not able").

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- Transfer – Indicate whether the individual is able to transfer himself/herself from one location to another ("Self"), with assistance ("Assist"), or if individual is unable to transfer himself/herself ("Not able").
- Toileting – Indicate whether the individual is able to use the toilet by himself/herself ("Self"), with assistance ("Assist"), or if individual is incontinent ("Incontinent"). If "Incontinent," specify whether incontinent of urine ("Urine"), stool ("Stool"), or both ("Urine/stool").
- Meals – Indicate whether the individual is able to feed himself/herself ("Self"), with assistance ("Assist"), or if individual has a feeding tube ("Tube"). If a feeding tube is used, specify the date the tube was last inserted or changed in the space provided in MM/DD/YY format.
- Hygiene – Indicate whether the individual is able to perform personal hygiene (e.g. brushing teeth, brushing hair, shaving) by himself/herself ("Self"), with assistance ("Assist"), or if individual is unable to perform personal hygiene ("Not able").
- Dressing – Indicate whether the individual is able to dress himself/herself ("Self"), with assistance ("Assist"), or if individual is unable to dress himself/herself ("Not able").

Current devices/recent (last 90 days) procedures*: If the individual does not have any current devices or recent (last 90 days) procedures, indicate "None." Otherwise, indicate "Yes" and specify any and all current devices or recent procedures (last 90 days) that apply to the individual. If the individual has an indwelling urinary catheter and/or a central line/PICC, specify the insertion date in MM/DD/YY format in the space provided. If the individual had a recent procedure (within the last 90 days) indicate "Procedure" and specify the type of procedure (e.g. surgery) and the date of procedure in MM/DD/YY format in the space provided.

Current medications*: Include an up to date medication administration record (MAR) with transport documents. The record should include date and time of last administration as well as diagnoses. This record should also be accessible to transport services. Indicate that a medication administration record has been included with transport documentation by checking the "MAR included" checkbox. Prior to transfer, the receiving facility should verify that the medications the individual is currently on (including method of administration), or a suitable alternative, are available.

Vaccination/test history*: If the individual has not received any of the listed vaccines/tests, indicate "None." Otherwise, indicate "Yes" and specify the date all applicable vaccines/tests were administered in MM/DD/YY format. For each applicable vaccine/test, indicate if vaccination/testing is reported by the patient (self-report vaccine/test receipt is "Yes") or not (self-report vaccine receipt is "No"). For tuberculin skin test (TST), also indicate whether the skin test result was positive ("Pos") or negative ("Neg").

Personal items sent with the patient/resident: If the individual was not transferred with any personal items, indicate "None." Otherwise, indicate "Specify" and list any personal items that were sent with the patient at the time of transfer. Personal items may include, but are not limited to, glasses, hearing aid(s), cane/walker, and wheelchairs.

Notes: Please include any additional notes related to the individual and/or the individual's continuing care in the space provided.

Contact information: All information is required unless otherwise indicated.

- Relative/Guardian/Power of Attorney (POA)

  - Name* – Specify the name of the individual's relative/guardian/POA in the space provided
  - Relationship – Specify the contact's relationship to the individual (e.g. spouse) in the space provided
  - Phone* – Specify the contact's phone number in the space provided
  - Notified? - Indicate whether or not the contact has been notified of the individual's transfer.
- Transferring facility representative completing form
  - Name/title* – Print the name and title of the representative of the transferring facility that is completing the form.
  - Signature – The representative of the transferring facility completing the form should sign the form.
  - Phone* – Specify the phone number of the transferring facility representative completing the form.

Copy checkboxes: All pages contain the same information. The page with "TRANSFERRING FACILITY COPY" marked (page 1) should remain in the medical record for the individual at the transferring facility. Page 2, "TRANSPORT/RECEIVING FACILITY COPY" should be given to transport services at the time of transfer by a transferring facility representative. This page should be given to the receiving facility at the time of transfer by a transport services representative and remain in the medical record for the individual at the receiving facility.

Transferring Facility Name*: _____
Transferring Facility Address*: _____ **INTERFACILITY TRANSFER FORM**
Transferring Facility Phone:* _____ **Fax:** _____

Transferred to:* _____ **Reason for transfer**:* _____
Transfer date/time:* _____/_____ **Attending physician**:*_____ **Phone**:* _____

Patient/resident demographics and vital signs (date/time taken _____/_____)
Last Name:* _____ **First Name**:* _____ **DOB**:* _____ **MRN**: _____
BP:* _____ **P**:* ___ **R**:* ___ **T(F)**:* ____ **O_2 SAT**:* ____ **HT(in)**: ____ **WT(lb)**: ____ **Diabetic?** ____ Glucose: _____
Language ☐ English ☐ Other: _____ **Mental status*** ☐ Alert ☐ Oriented ☐ Other: _____
Allergies* ☐ None ☐ Yes: _____ **Pain** Level (0-10): ___ Site: _____
At risk alerts* ☐ None ☐ Falls ☐ Aspiration ☐ Pressure ulcers ☐ Seizures ☐ Elopement ☐ Other: _____
Advanced directives* ☐ DNR ☐ DNI ☐ MOST ☐ Living Will ☐ Proxy, Contact _____

Current isolation precautions*/required PPE (Check, if indicated)
☐ No ☐ Yes, specify ☐ Contact ☐ Droplet ☐ Airborne
PPE, specify ☐  ☐  ☐ 

Organisms / infections* ☐ None ☐ Yes, specify type/date	**Current infection**	**Hx/Colonized**	**Pending result**
Multi-drug resistant organisms (MDROs)	Date	Date	Date
Methicillin-resistant Staphylococcus aureus (MRSA)	☐ _____	☐ _____	☐ _____
Vancomycin-resistant Enterococci (VRE)	☐ _____	☐ _____	☐ _____
Acinetobacter not susceptible to carbapenems	☐ _____	☐ _____	☐ _____
Enterobacteriaceae resistant to carbapenems (i.e. CRE)	☐ _____	☐ _____	☐ _____
Extended-spectrum beta-lactamase producer (ESBL)	☐ _____	☐ _____	☐ _____
Clostridium difficile (C. diff)	☐ _____	☐ _____	☐ _____
Other: _____ (e.g. Group A Streptococcus (GAS), lice, scabies, disseminated shingles, norovirus, flu, TB, etc.)	☐ _____	☐ _____	☐ _____

Current or recent (last 7 days) symptoms ☐ None ☐ Yes, specify
☐ Draining wounds ☐ Concerning rash (e.g. vesicular) ☐ Cough/uncontrolled respiratory secretions
☐ Vomiting ☐ Acute diarrhea or incontinent of stool ☐ Other: _____

Sensory status and activities of daily living*

Vision	Hearing	Speech	Ambulate	Transfer	Toileting	Meals	Hygiene	Dressing
☐ Good	☐ Good	☐ Good	☐ Self	☐ Self	☐ Self	☐ Self	☐ Self	☐ Self
☐ Poor	☐ Poor	☐ Difficult	☐ Assist	☐ Assist	☐ Assist	☐ Assist	☐ Assist	☐ Assist
☐ Blind Sfy: ___	☐ Deaf Sfy: ___	☐ Aphasia	☐ Not able	☐ Not able	☐ Incontinent Sfy: _____	☐ Tube Date: _____	☐ Not able	☐ Not able

Current devices / recent (last 90 days) procedures* ☐ None ☐ Yes, specify
☐ Tracheostomy tube ☐ Hemodialysis catheter ☐ Procedure, specify type _____ and date _____
☐ Gastrostomy tube ☐ Urinary catheter (date inserted) _____ ☐ Central line/PICC (date inserted) _____

Current medications* ☐ None ☐ Yes, refer to attached MAR

Vaccination / test history* ☐ None ☐ Yes, specify

Vaccine/test	Influenza (seasonal)	Pneumococcal	Zoster	Td	Tdap	Tuberculin skin test
Date administered	_____	_____	_____	_____	_____	_____
Self-report vaccine/ test receipt?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No Result: ☐ Pos ☐ Neg

Personal items sent with patient/resident
☐ None ☐ Specify (e.g. glasses, etc.): _____

Notes:

Contact information
Relative/Guardian/POA
Name:* _____ Relationship: _____ Phone:* _____ Notified? ☐ Yes ☐ No
Transferring facility representative completing form
Name/title (print):* _____ Signature: _____ Phone:* _____

Transferring Facility Name*: _____
Transferring Facility Address*: _____ **INTERFACILITY TRANSFER FORM**
Transferring Facility Phone:* _____ **Fax:** _____

Transferred to:* _____ **Reason for transfer**:* _____
Transfer date/time:* _____/_____ **Attending physician**:*_____ **Phone**:* _____

Patient/resident demographics and vital signs (date/time taken _____/_____)
Last Name:* _____ **First Name**:* _____ **DOB**:* _____ **MRN**: _____
BP:* _____ **P**:* ___ **R**:* ___ **T(F)**:* ____ **O_2 SAT**:* ____ **HT(in)**: ____ **WT(lb)**: ____ **Diabetic?** ____ Glucose: _____
Language ☐ English ☐ Other: _____ **Mental status*** ☐ Alert ☐ Oriented ☐ Other: _____
Allergies* ☐ None ☐ Yes: _____ **Pain** Level (0-10): ___ Site: _____
At risk alerts* ☐ None ☐ Falls ☐ Aspiration ☐ Pressure ulcers ☐ Seizures ☐ Elopement ☐ Other: _____
Advanced directives* ☐ DNR ☐ DNI ☐ MOST ☐ Living Will ☐ Proxy, Contact _____

Current isolation precautions*/required PPE (Check, if indicated)
☐ No ☐ Yes, specify ☐ Contact ☐ Droplet ☐ Airborne
PPE, specify ☐  ☐  ☐ 

Organisms / infections* ☐ None ☐ Yes, specify type/date	**Current infection**	**Hx/Colonized**	**Pending result**
Multi-drug resistant organisms (MDROs)	Date	Date	Date
Methicillin-resistant Staphylococcus aureus (MRSA)	☐ _____	☐ _____	☐ _____
Vancomycin-resistant Enterococci (VRE)	☐ _____	☐ _____	☐ _____
Acinetobacter not susceptible to carbapenems	☐ _____	☐ _____	☐ _____
Enterobacteriaceae resistant to carbapenems (i.e. CRE)	☐ _____	☐ _____	☐ _____
Extended-spectrum beta-lactamase producer (ESBL)	☐ _____	☐ _____	☐ _____
Clostridium difficile (C. diff)	☐ _____	☐ _____	☐ _____
Other: _____ (e.g. Group A Streptococcus (GAS), lice, scabies, disseminated shingles, norovirus, flu, TB, etc.)	☐ _____	☐ _____	☐ _____

Current or recent (last 7 days) symptoms ☐ None ☐ Yes, specify
☐ Draining wounds ☐ Concerning rash (e.g. vesicular) ☐ Cough/uncontrolled respiratory secretions
☐ Vomiting ☐ Acute diarrhea or incontinent of stool ☐ Other: _____

Sensory status and activities of daily living*

Vision	Hearing	Speech	Ambulate	Transfer	Toileting	Meals	Hygiene	Dressing
☐ Good	☐ Good	☐ Good	☐ Self	☐ Self	☐ Self	☐ Self	☐ Self	☐ Self
☐ Poor	☐ Poor	☐ Difficult	☐ Assist	☐ Assist	☐ Assist	☐ Assist	☐ Assist	☐ Assist
☐ Blind Sfy: ___	☐ Deaf Sfy: ___	☐ Aphasia	☐ Not able	☐ Not able	☐ Incontinent Sfy: _____	☐ Tube Date: _____	☐ Not able	☐ Not able

Current devices / recent (last 90 days) procedures* ☐ None ☐ Yes, specify
☐ Tracheostomy tube ☐ Hemodialysis catheter ☐ Procedure, specify type _____ and date _____
☐ Gastrostomy tube ☐ Urinary catheter (date inserted) _____ ☐ Central line/PICC (date inserted) _____

Current medications* ☐ None ☐ Yes, refer to attached MAR

Vaccination / test history* ☐ None ☐ Yes, specify

Vaccine/test	Influenza (seasonal)	Pneumococcal	Zoster	Td	Tdap	Tuberculin skin test
Date administered	_____	_____	_____	_____	_____	_____
Self-report vaccine/ test receipt?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No Result: ☐ Pos ☐ Neg

Personal items sent with patient/resident
☐ None ☐ Specify (e.g. glasses, etc.): _____

Notes:

Contact information
Relative/Guardian/POA
Name:* _____ Relationship: _____ Phone:* _____ Notified? ☐ Yes ☐ No
Transferring facility representative completing form
Name/title (print):* _____ Signature: _____ Phone:* _____