NH DIVISION OF
Public Health Services
Improving health, preventing disease, reducing costs for all
Department of Health and Human Services

# NEW HAMPSHIRE INFECTION CONTROL INTERFACILITY TRANSFER FORM

To be completed by the discharging facility, Please print or type
One copy is to stay with the patient's record while the other is to be given to the receiving facility

Date of Discharge: _____/_____/_____

❑ Please notify the New Hampshire Division of Public Health Services when patients known to have an MDRO or organism of public health significance (e.g. CRE, CP-CRE, VRSA, *C.auris*, etc.) are transferred to an out of state facility so the appropriate information can be relayed to the receiving state's public health department. Phone: 603-271-4496

## FACILITY INFORMATION

| | | |
|---|---|---|
| Discharging Facility Name: | Facility Contact Person: | Phone number:<br>(     ) |
| Address: | City: | State: | ZIP Code: |
| Receiving Facility Name: | Facility Contact Person: | Phone number:<br>(     ) |
| Address: | City: | State: | ZIP Code: |

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient's last name | First | Middle |
| Birth date:        /        / | Age: | Sex: ❑ M     ❑ F |

Please check all types of precautions which prompted the use of transfer form and explain why (ex: TB, CP-CRE, Varicella, Influenza):

| Type of precaution: | Why/ notes: | Any relevant testing results: |
|---|---|---|
| ❑ Contact | | |
| ❑ Airborne | | |
| ❑ Droplet | | |
| ❑ Other _____ | | |

Has the transporting agency been notified of the required infection prevention precautions?     ❑ Yes          ❑ No
Has the patient been educated about what infection control precautions are necessary and why?     ❑ Yes          ❑ No
Have the patient's family and/or legal guardians been educated about what infection control precautions are necessary and why?
                                                                                                     ❑ Yes          ❑ No

Does this patient/resident currently have any significant symptoms relevant to infection control, such as diarrhea, incontinence of urine or stool, open wounds, etc.? ❑ Yes          ❑ No

If **YES**, what types of symptoms? _____

Additional Notes:

| | |
|---|---|
| Printed name of person completing the form: | Role: |
| Signature | Date |