

Inter HealthCare Transfer Form

LCC IPC Guidance

Next Review October 2025

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Version:	4
Developed by:	The IPC Team on behalf of the Lancashire County Council
Date Ratified:	Oct 2024

Inter Health Care Transfer Form

Notification for a resident carrying or infected with an infectious organism

Service user details: (insert label if available) Name:	Consultant name:	
Address:	Consultant Contact no:	
	GP name:	
	GP contact no: GP telephone No.	
Date of birth: NHS number:		
Transferring facility:	Receiving facility:	
Facility name	Facility name	
Details (e.g., care setting, community hospital, hospice,	Details (e.g., care setting, community hospital,	
district nurse, GP)	hospice, district nurse, GP)	
Contact name:	Contact name:	
Contact no:	Contact no:	
Diagnosis:	Infection: Yes□ / No□	
Diagnosis/confirmed organism details	Colonisation: Yes□ / No□	
Infection prevention and control precautions required/i	n place:	

Is the service user aware of their colonisation / infection statu	s? Yes□ / No□			
If no, please give reason:				
Has the service user received information about their condition? (Patient leaflet) Yes \Box / No \Box				
has the service user received information about their conditions (Patient leanet)				
Has ambulance service been informed?	Yes□ / No□			
This should be done when booking the transfer.				
If no, please give reason.				
Name of staff member completing form:				
Name:	Contact number:			
Nume.	contact number.			
Date completed:				

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