**Date:** [Insert Date]

**To:** Receiving Facility Name / Attending Physician
**From:** Sending Facility Name / Department

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## SUBJECT: TRANSFER OF PATIENT WITH ONGOING MDRO TREATMENT

**Patient Name:** [Insert Name]
**Date of Birth:** [Insert DOB]
**Medical Record Number:** [Insert MRN]

**1. MDRO STATUS**
The patient has tested positive for the following Multidrug-Resistant Organism(s):
[ ] MRSA (Methicillin-resistant Staphylococcus aureus)
[ ] VRE (Vancomycin-resistant Enterococcus)
[ ] CRE (Carbapenem-resistant Enterobacteriaceae)
[ ] Candida auris
[ ] Other: [Specify Organism]

**2. INFECTION SITE & STATUS**
**Site of Infection/Colonization:** [e.g., Blood, Wound, Sputum, Urine]
**Current Status:** [ ] Active Infection [ ] Colonization Only

**3. CURRENT TREATMENT REGIMEN**
**Antibiotic/Antifungal Medication:** [Insert Medication Name]
**Dosage and Frequency:** [Insert Dose/Route]
**Start Date:** [Insert Date]
**Duration/End Date:** [Insert Planned Duration]
**Last Dose Administered:** [Insert Time and Date]

**4. PRECAUTION REQUIREMENTS**
Based on the MDRO status above, the patient is currently on:
[ ] Contact Precautions
[ ] Enhanced Barrier Precautions
[ ] Droplet Precautions

**5. LAB RESULTS ATTACHED**
[ ] Culture and Sensitivity Reports
[ ] Most Recent CBC/BMP
[ ] Relevant Imaging (X-ray/CT)

**6. POINT OF CONTACT**
For clinical questions regarding MDRO management, please contact:

**Name/Title:** [Insert Name]
**Phone Number:** [Insert Phone Number]

Sincerely,

[Your Signature]
[Your Printed Name and Title]