

GP Patient Admission Form

To Assess Risk of *Clostridium difficile* Infection in Patients being admitted to Hospital

To be completed for **ALL** patients being referred for admission

Patient Name Date of Birth/...../.....

Health & Care Number (if known)

Address (own Home/Residential Home/Nursing Home)

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In the last 4 weeks this patient has:	Yes	No
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1. Had antibiotic therapy	<input type="checkbox"/>	<input type="checkbox"/>
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2. Had/has diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>
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3. Had a positive <i>C. difficile</i> toxin test	<input type="checkbox"/>	<input type="checkbox"/>
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4. Ongoing <i>C. difficile</i> infection	<input type="checkbox"/>	<input type="checkbox"/>
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Signed Date.....

This must be recorded in the patient's medical notes

Infection Prevention and Control Admission Risk Assessment Form

To be completed by the nurse admitting a patient OR accepting a transfer

Patient Details	Transferring Hospital Details (if applicable)
Name:	Date of Admission:
Address:	Ward:
Hosp. No.	Consultant:
Date of Birth:	Reason for original admission/Transfer:
Date of Admission:	Name of staff member in transferring hospital supplying information:
Ward:	

Risk Assessment for Infective Diarrhoea and/or Vomiting

Is the patient/client currently having diarrhoea and/or vomiting where infection has not been ruled out as the cause?	Yes/No
Has the patient/client been in a ward or nursing home where other patients have been having diarrhoea &/or vomiting?	Yes/No
Has the patient's/client's family had diarrhoea and/or vomiting	Yes/No
Has the patient/client a history of <i>Clostridium difficile</i> ?	Yes/No
If yes, date of first <i>C. difficile</i> toxin positive specimen _____	

Known History of Mutliresistant Organisms or Other Infection Risk

Has the patient/client a history of having MRSA ESBL VRE/GRE Other _____

Is the patient/client and their family aware of their diagnosis? Yes / No / Unknown	Is the patient/client currently being nursed in a single room? Yes/No
	Was the patient/client placed in an isolation room on admission- Yes/No

Other relevant information: (e.g. Current antibiotic treatment/or contact with infection).

Infection Prevention and Control Nurse informed? Yes/No

Name of staff member completing form:

Signature & Print Name:

Contact Number:

Date:

TO BE COMPLETED BY DISCHARGING PHYSICIAN
***Clostridium difficile* Transfer/Discharge Checklist**
(For patients discharged to residential/care home/GP or other healthcare facility)

Patient Details

Name: _____ Date of Birth ____/____/____

Address: _____

Hosp. No. _____ Date of Admission: ____/____/____ Ward _____

Date of last positive *Clostridium difficile* toxin specimen:

Patient treated with Metronidazole

Yes No

Total Number of courses =

1st Course

Start Date _____

Stop Date _____

Most Recent Course

Start Date _____

Stop Date _____

Patient treated with Vancomycin

Yes No

Total Number of courses =

1st Course

Start Date _____

Stop Date _____

Most Recent Course

Start Date _____

Stop Date _____

Is patient still on antibiotic therapy

Yes No

If **YES**, please give details

Name of Antibiotic: _____

Continue for: _____

If **Tapered** course, please give exact details

Tapered Course details _____

Patient now 72 hours symptom free from diarrhoea

Yes No

If **YES**, date of last episode of diarrhoea

Date: _____

If **NO**, Infection Control Risk Assessment for transfer undertaken

Yes No

Name of Infection Prevention and Control Specialist carrying out risk assessment

Name: _____ Date _____

Signature: _____ Print Name _____

Designation: _____ Date: _____