

## 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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<b>In the last 4 weeks this patient has:</b>	<b>Yes</b>	<b>No</b>
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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**