

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: _____