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: _____