

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: