GAIN
GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

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) ………………………………………

……………………………………………………………………………………………......

……………………………………………………………………………………………..

In the last 4 weeks this patient has:	**Yes**	**No**
1. Had antibiotic therapy	☐	☐
2. Had/has diarrhoea	☐	☐
3. Had a positive C. difficile toxin test	☐	☐
4. Ongoing *C. difficile* infection	☐	☐

Signed ………………………………………………. Date…………………………….

This must be recorded in the patient's medical notes