



# RECIPIENT F.M.T. REQUEST FORM

Patient Identification Label

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

The above named patient is scheduled for FMT on: \_\_\_\_\_

**The following criteria have been met:**

The patient (recipient) has a documented positive Clostridium difficile toxin on: \_\_\_\_\_

**AND**

The patient (recipient) has failed two courses of antibiotics:

ANTIBIOTIC	DATES USED

**OR**

The patient (recipient) has failed one course of antibiotics and has required hospitalization

ANTIBIOTIC	DATES USED

HOSPITAL NAME	ADMISSION DATES

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

