5-Hole 1/4 1 3/8 c-to-c

Missouri Baptist
MEDICAL CENTER
BJC HealthCare

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

MBMC 13-3343-1024