UNIVERSITY OF BIRMINGHAM | MICROBIOME TREATMENT CENTRE

Faecal Microbiota Transplant Request Form for CDI

This form is valid for a single treatment of FMT for the named patient. We advise a copy of this request is placed in the patients clinical notes. Should a further dose be required additional FMT request and order forms will need to be completed.

IMPORTANT: It is a condition of our MHRA licence that outcome data is supplied at 7 days and 90 days post FMT administration. Failure to adhere to this may result in further FMT requests being refused.

REQUESTER'S INFORMATION

Name, Position and Address:

Contact no: Mobile

Contact no: Secretary

Email:

Date of Request:

Consultant Signature: *(Please sign)*

Consultant Name: *(Please print)*

PATIENT INFORMATION

Surname:

First Name:

Date of Birth:

Hospital and Ward:

NHS Number:

Hospital Number/PID:

Sex: M ☐ F ☐ Pregnant: Y ☐ N ☐

Is FMT contraindicated in this patient? Y ☐ N ☐ If Y provide details:

Is the patient immunosuppressed/immunocompromised? Y ☐ N ☐

If Y provide details:

Please contact us if you have any particular requirements regarding FMT for your patient (e.g FMT from donors with no serological evidence of prior CMV infection)

PREVIOUS *C. difficile* HISTORY (UPTO PAST 1 YEAR)

No. of previous episodes of CDI:

Associated *C. difficile* Ribotypes:

Information on previous confirmed *C. difficile* episodes:

Episode	Start Date	End Date	PCR +	EIA +

Antibiotic treatment given for all previous CDI episodes:

Antibiotic (dose)	Start Date	End Date

Faecal Microbiota Transplant Request Form for CDI

CURRENT *C. difficile* EPISODE

Date of onset of current symptoms:

Bristol stool type: Select Type

Result of CDI test (please complete as appropriate):

Stool frequency (per day):

Stool toxin positive by Enzyme Immune Assay: Select

Stool toxin gene positive by PCR: Select

Highest WBC (x10^9/L):

Highest Serum Creatinine (umol/L):

Antibiotic treatment given for all current CDI episodes:

Lowest Albumin (ug/L):

Antibiotic (dose)	Start Date	End Date

Other antibiotics:

Antibiotic (dose)	Start Date	End Date

Please tick those that apply: Y N

- Abdominal pain: Mild ☐ ☐
- Abdominal pain: Severe ☐ ☐
- Peritonism ☐ ☐
- Fever >38.5°C ☐ ☐
- Hypotension ☐ ☐
- Ileus ☐ ☐
- Shock ☐ ☐
- Toxic Megacolon ☐ ☐
- Colitis on radiology ☐ ☐

FMT SUPPLY INFORMATION

FMT ordering is available Monday to Friday 9am–3pm by emailing a completed copy of this form to bhs-tr.FMT@nhs.net

The price of a single FMT aliquot is £1300. Please complete this form in full. Subject to ratification of the completed FMT request form, information given on the accompanying FMT Order form will be used to complete the order.
Specialist advice in relation to FMT is available:

- Monday to Friday from 9:00-15:00 via the Microbiome Treatment Centre Clinical team on 0121 414 4547 and via bhs-tr.FMT@nhs.net

Confirmation of receipt of request and order will be provided within 24 hours of submission (Mon-Fri), if not received please contact the FMT team on bhs-tr.FMT@nhs.net or 0121 414 4547.

REQUEST RATIFICATION *FOR INTERNAL USE ONLY*

Name of ratifying clinician:

Signature:

Position:

Date of ratification:

Comments:

Based on the information provided, has the request for Specials use been ratified? **Yes** ☐ **No** ☐