

**CLOSTRIDIUM DIFFICILE (C. DIFF) TESTING**

Answer the following then send completed form to the lab with sample:

1. Length of stay (Note: Date of Admission counts as Day 1): \_\_\_\_\_
2. Has the patient had 4 or more loose/liquid stools in past 24 hours? **YES NO**
3. Has patient had recent antibiotic use or colon surgery? **YES NO**
4. Is patient taking laxative/stool softeners/lactulose? **YES NO**
5. Is this the first Cdiff or GI Panel for this patient in past seven days? **YES NO**

Name of staff member completing \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date / Time

**SUBMIT COMPLETED FORM TO THE LABORATORY**

**WITH ALL C. DIFF STOOL SAMPLES INCLUDING GI PATHOGEN PANELS**