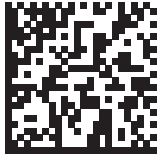


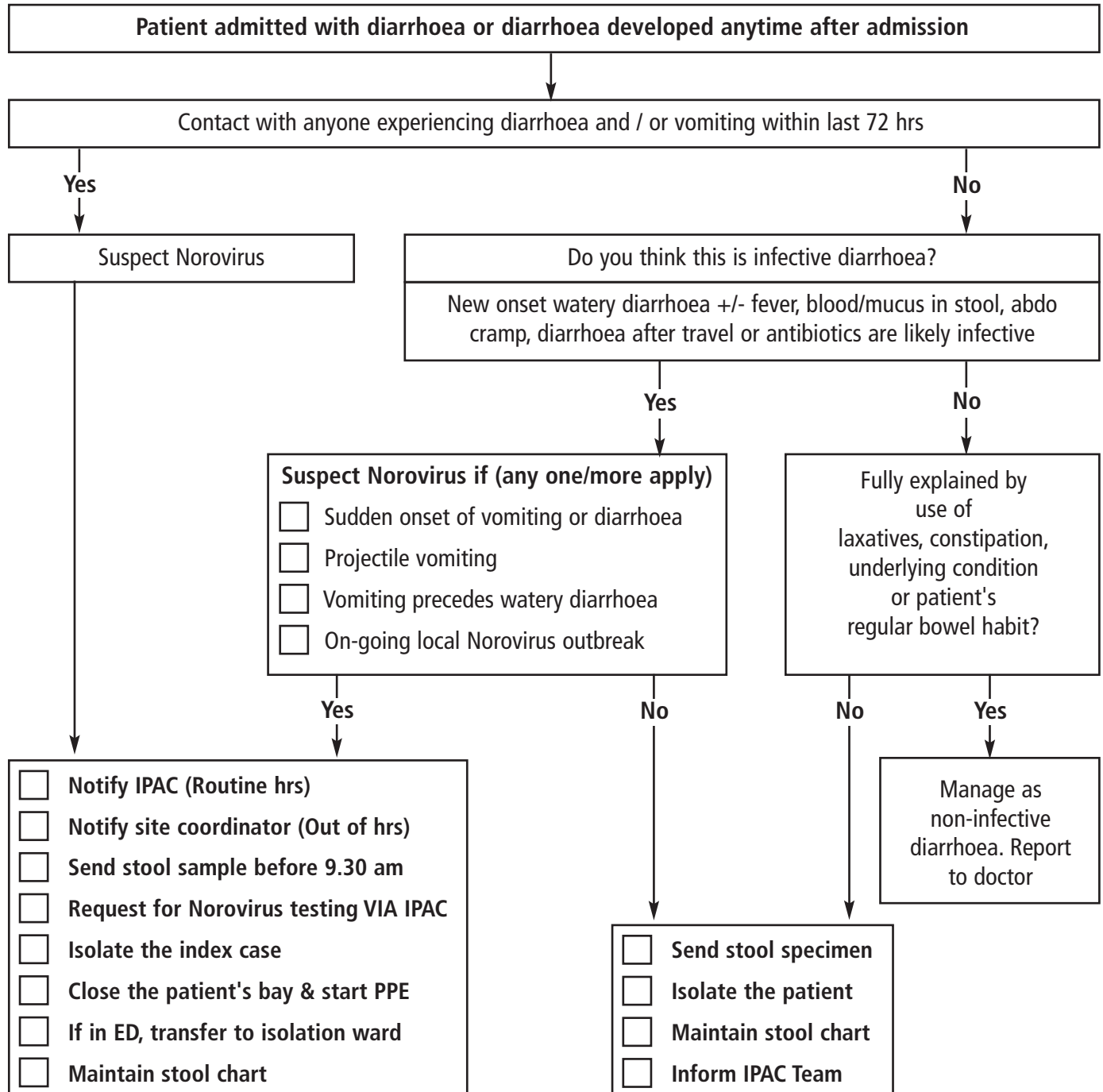
Place patient sticker **within** this box



Diarrhoea Assessment in Adult Patients (Stool type 5,6 or 7)



Person completing this form: Nurse Doctor



Contact microbiology if there is suspicion of severe C. difficile infection for urgent empiric treatment advice

Name of Nurse: _____ Signature: _____ Date: _____

Name of Doctor: _____ Signature: _____ Date: _____