Clostridium Difficile Outbreak Line List for Acute Care Facilities

Facility Name: _____ Facility Contact Name: _____ Phone: _____

Patient Name	Date of Birth	Age	Sex	Room/Bed #	Date admitted to the hospital	Admission Diagnosis	Date of (most recent) Admission to the CCU	Unit or floor before CCU	admitted from:	Date of Onset of Diarrhea	Severity / Compli-cations?	Date Well	Stool Testing Results		Healthcare Facility Stay(s) during Last 3 Months		Antimicrobial agents during Previous 3 Month (Y/N)	Proton pump inhibitors (PPI) or H2 blockers (Y/N)	NG tube or entral feeding? (Y/N)	Mechanical ventilation (Y/N)	Surgical procedures since hospital admission? (Y/N)	Underlying Conditions (specify)
													Type of test / result	Date	Date	Facility Name						