EMERGENCY FMT ORDER FORM

OpenBiome is committed to ensuring safe access to investigational FMT while we suspend regular shipping activities.

If you have a patient with *Clostridioides difficile* infection that is fulminant\(^1\) or life-threatening or otherwise requires prompt intervention to avoid major morbidity and/or mortality, please fill out the form below and return this form to info@openbiome.org or by fax to 617-575-2201. At this point in time OpenBiome material can only be used in patients which meet these criteria. These steps are important to confirm that units are being utilized for medical emergencies only.

**Please select the option below that best describes your patient’s case:**

- [ ] (A) The patient has been diagnosed with fulminant or life-threatening *C. difficile* infection not responsive to standard therapy and requires prompt intervention.
- [ ] (B) The patient has been diagnosed with recurrent or refractory *C. difficile* infection that is **NOT** fulminant or life-threatening.

If the patient has **not** been diagnosed with fulminant or life-threatening *C. difficile* infection, please provide additional clinical explanation about the patient’s need for emergency treatment.

**DO NOT INCLUDE PHI**

<table>
<thead>
<tr>
<th>Patient age: _____ years</th>
<th>Sex: Male/Female/Other (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, ___________________________(treating clinician name), certify that to the best of my knowledge, the above information is complete and correct.

Clinician Signature: ___________________________ Date: __________

\(^1\)Fulminant CDI, previously referred to as severe, complicated CDI, may be characterized by hypotension or shock, multi organ dysfunction, ileus or toxic megacolon

---

**OpenBiome use only**

- Role: [ ] (A) Non-Clinician [ ] (B) Clinician
- Shipment approved: [ ] Yes [ ] No
- Printed Name: ___________________________ Signature: ___________________________ Date: __________
- QA Signature: ___________________________ Date: __________