UTHealth The University of Texas Health Science Center at Houston

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Generic Pre-Screening Form

Program for Restoration of Intestinal Microbiota (PRIM)

Name of Potential Recipient_____Today's Date_____

Contact Phone _____Contact Email_____

Residential City/ State/ Zip code _____

(Circle Yes or No)

Yes / No Are you 18 years of age or older?

Yes / No Have you been referred by a physician treating your C. *difficile* infection (CDI) or do you have an attending physician who will provide non-transplant care for you? Please provide Physician's

Name_____ Phone_____

Fax_____Email_____

Yes / No Have you been diagnosed with ≥ 3 bouts of recurrent CDI in outpatients or ≥ 2 bouts of CDI in an inpatient with ≥ 2 positive fecal tests for *C. difficile* toxin within last one year?

Yes / No Do you have history of Ulcerative Colitis or Crohn's Disease or Celiac disease?

Yes / No Have you been diagnosed with Irritable bowel Syndrome (IBS)?

Yes / No Have you had a colostomy (colon removal) in the past?

Yes / No Have you completed at least one course of antibiotic therapy for CDI (≥ 10 days of one of the three anti-CDI treatments: vancomycin; metronidazole; fidaxomicin?

Yes / No Have you taken antibiotics for any condition other than for CDI in the last 14 days?

Yes / No Are you currently experiencing diarrhea (≥ 3 watery stools/day for 2 consecutive days)?

Yes / No Have you had a severe or unstable underlying disease requiring frequent change in medical treatment? If yes, indicate medical condition and therapy

_____

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IRB NUMBER: HSC-SPH-17-0614
IRB APPROVAL DATE: 11/28/2017

List C. Difficile Episodes within last One Year Only (Begin listing from recent episode)

No.	Date of C. *difficile* Episode	Stool test result for C. Difficile episode? **Positive Negative Not tested**	Were you hospitalized for this episode? **Yes/No**	C. Difficile Medication Taken for episode (Medication name/dose)	C. Difficile Medication Start Date	C. Difficile Medication Stop Date	Did diarrhea improve while on medication? **Yes/No**

List Current Medications and Medical Conditions for which you are being treated

Medication Name	Dosage	Route (Oral, Topical Inhaled, injectable)	Medication Start Date	Medical Condition/ Indication

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Herbert L. DuPont, MD, MACP
Medical Director,
Berthelsen Program for Restoration of
Intestinal Microbiota

1200 Pressler Street, E-743
Houston, TX 77030
Phone: 713-500-9366/ 713-442-0762

Authorization for Release of Healthcare Information

Disclosure Purpose: Consideration for Fecal Microbiota Transplantation study eligibility for recurrent Clostridium *difficile* Infection (CDI)

I hereby authorize the transfer/receipt of the following healthcare information from healthcare providers for Fecal Microbiota Transplantation study pre-screening eligibility review.

- Clostridium *difficile* laboratory reports
- Clostridium *difficile* consultation notes
- Clostridium *difficile* prescription history
- Recent medical history/medications

Sent to: Dr. Herbert L. DuPont
UT HEALTH and Kelsey-Seybold Clinic
Faxed to: 713-442-1229
Phone: 713-442-1220

Physician / Hospital Name	Phone number	Fax Number

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug/alcohol abuse, mental/psychiatric related illnesses, or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing to Dr. Herbert DuPont at the address 1200 Pressler Street, E-743, Houston, TX 77030 and the medical record department of Kelsey-Seybold Clinic, Phone: 713-442-5700.

Patient Name: _____ Date of Birth: _____

_____ _____
Signature of Patient/ Legal Representative Date

_____ _____
Legal Representative Name (if any) Legal Representative's Authority to Act for Patient