Women's Medicine Collaborative*
A Lifespan Partner
BY WOMEN. FOR WOMEN.™
*The Miriam Hospital d.b.a. Women's Medicine Collaborative

Center for Women's Gastrointestinal Medicine
146 West River St. Providence, RI 02904
Phone: (401) 793-7080
Fax: (401) 793-7801

Fecal Transplant ~ Intake Form

Please fill out and FAX Attn: Kathy Primo

PATIENT _____ DOB _____ /_____ / _____

ADDRESS _____

HOME _____ CELL _____ E-MAIL_____

May we leave a message stating the call is from "Women's Medicine Collaborative", "GI Medicine" or "Dr. ____'s office"? ☐ Yes ☐ No

PRIMARY INSURANCE_____ID#_____

SECONDARYINSURANCE_____ID#_____

REFERRING PROVIDER_____PHONE_____FAX_____

Local Laboratory Telephone and Fax #_____

Primary Care Doctor (Name/Contact Info) _____

Gastroenterologist and/or Infectious Disease Specialist (Name/Contact info) _____

Date of Initial *C Difficile* Diagnosis _____

Number of Relapses_____

Have you been hospitalized as a result of your C Difficile Infection/how many times? _____ /_____

Prior Treatments /please check and indicate number of courses and duration of each including tapering regimens:

- ☐ Metronidazole (Flagyl)_____
- ☐ Vancomycin _____
- ☐ Fidaxomicin (Dificid)_____
- ☐ Rifaximin (Xifaxin)_____
- ☐ Nitazoxanide (Alinia)_____
- ☐ Probiotics:
  - ☐ Florastor (S. boulardii)_____
  - ☐ Culturelle (Lactobacillus GG)_____
  - ☐ Other_____

Other medical problems_____

Prior Surgeries_____

Have you ever had a colonoscopy? When? Results , if known._____

Allergies_____

Current Medications_____