

Faecal Microbiota Transplant (FMT) for recurrent or refractory *Clostridium difficile* Infection (CDI)

Donor screening questionnaire – Part 1

Name:

DOB:

Hospital number:

NHS number:

Contact details (preferably mobile):

Date of assessment:

Name / position of assessor:

Donor type	<input type="checkbox"/> Named donor <input type="checkbox"/> Anonymous donor
If Named donor, name and hospital number of recipient	
If Named donor, relationship to recipient	
If Named donor, does the recipient normally live in the same dwelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age	Exclude if <18 or >60
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnicity	<input type="checkbox"/> White - White British <input type="checkbox"/> White - White Irish <input type="checkbox"/> White - Other <input type="checkbox"/> Mixed race – White and Black Caribbean <input type="checkbox"/> Mixed race – White and Black African <input type="checkbox"/> Mixed race – White and Asian <input type="checkbox"/> Mixed race – Other <input type="checkbox"/> Asian or Asian British – Indian <input type="checkbox"/> Asian or Asian British – Bangladeshi <input type="checkbox"/> Asian or Asian British – Pakistani <input type="checkbox"/> Asian or Asian British – Other <input type="checkbox"/> Black or Black British – Caribbean <input type="checkbox"/> Black or Black British – African <input type="checkbox"/> Black or Black British – Other <input type="checkbox"/> Chinese <input type="checkbox"/> Other
Height cm	

Weight kg	
BMI	Exclude if BMI>25
Has your weight changed by more than 5lb / 2kg in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your diet (as many as apply):	Detail: <input type="checkbox"/> Omnivore <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Kosher <input type="checkbox"/> Halal <input type="checkbox"/> Raw food only <input type="checkbox"/> Pescatarian <input type="checkbox"/> No red meat <input type="checkbox"/> Low carbohydrate <input type="checkbox"/> Lactose free <input type="checkbox"/> Gluten free <input type="checkbox"/> Other
How many portions of fruit and vegetables do you consume per day?	<input type="checkbox"/> one or less <input type="checkbox"/> two to three <input type="checkbox"/> three to four <input type="checkbox"/> five to six <input type="checkbox"/> seven or more
How many servings of cow, sheep or goats milk do you consume per day?	<input type="checkbox"/> one or less <input type="checkbox"/> two to three <input type="checkbox"/> three to four <input type="checkbox"/> five to six <input type="checkbox"/> seven or more
Alcohol – units/week	
Smoking/day	
Normal bowel habit – average Bristol Stool Consistency	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 Exclude if 6 or 7
Normal bowel habit – average frequency	<input type="checkbox"/> >2/day <input type="checkbox"/> once to twice daily <input type="checkbox"/> once / 2 days <input type="checkbox"/> <once / 2 days Exclude if active diarrhoea (>3 UBM/day for at least 2 consecutive days)

During the past 7 days how many days were you physically active for a cumulative total of >60 mins/day?	
Have you ever been rejected as a blood donor/told not to donate? If yes, why?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if YES
What is your country of birth?	
Have you ever resided in another country (other than UK) for >5 years? If so which countries and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently have a profession that is associated with an increased risk of blood-borne transmissible diseases (e.g. daily contact with patients/inmates)? If yes, what profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if health/social care worker with direct patient contact
Have you ever had a needle-stick or injury from a blood contaminated object from someone else? If yes, when and how was this follow up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever injected yourself or been injected with illegal or non-prescribed drugs including body building drugs or cosmetics (even if this was only once or a long time ago?)	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if YES
Have you ever had a tattoo? If yes, when and in which country was it performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if within past 4 months
Have you ever had a piercing? If yes, when and in which country was it performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if within past 4 months
Have you ever had acupuncture? If yes, when and in which country was it performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if within past 4 months
Have you ever had an operation or undergone clinical treatment in a hospital with poor hygienic conditions? If yes, when and in which country was it performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a rare infectious disease (e.g. tuberculosis, trypanosomiasis)? If yes, when and which disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been vaccinated against Hepatitis A or B? If yes, which?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you used any antibiotics in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if Yes
Have you had a fever in the last 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if Yes
Have you ever been incarcerated in prison?	<input type="checkbox"/> Yes <input type="checkbox"/> No Exclude if in past 4 months
Have you ever been immunosuppressed (e.g. during treatment for cancer, or for a solid organ transplant)? If yes, when and why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had major gastrointestinal surgery? If yes, when and why?	<input type="checkbox"/> Yes <input type="checkbox"/> No Relative exclusion criteria
Have you ever suffered from metabolic syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No Relative exclusion criteria
Have you ever suffered from any autoimmune condition (e.g. rheumatoid), asthma or eczema? If yes, which, and do you take any treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Relative exclusion criteria
Have you ever had any chronic pain or fatigue syndromes? If yes, which?	<input type="checkbox"/> Yes <input type="checkbox"/> No Relative exclusion criteria
Have you any history of CJD or other prion disease in your family? If yes, please specify Patients should be considered to be at risk from genetic forms of CJD if they have or have had <ol style="list-style-type: none"> 1. Genetic testing, which has indicated they are at significant risk of developing CJD or other prion disease 2. A blood relative known to have a genetic mutation indicative of genetic CJD or other prion disease 3. Two or more blood relatives affected by CJD or other prion disease 	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever received growth hormone or gonadotrophic treatment? If yes, please specify; <ol style="list-style-type: none"> i) Whether the hormone was derived from human pituitary glands ii) The year of the treatment iii) Whether the treatment was received in the UK or in another country 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Recipients of hormone derived from human pituitary glands eg growth hormone or gonadotrophin have been identified as potentially at risk of CJD. In the UK, the use of human growth hormone was stopped in 1985 but human-derived products may have been continued to be used in other countries. In the UK, the use of human-derived gonadotrophin was discontinued in 1973 but may have been continued in other countries after this time.</p>	
<p>Have you ever had surgery on your brain or spinal cord? People who underwent intradural neurosurgical or spinal procedures before August 1992 may have received a graft of human-derived dura mater and should be treated as at increased risk, unless evidence can be provided that human-derived dura mater was not used. Patients who received a graft of human-derived dura mater between 1980 and August 1992 are at increased risk of both sporadic CJD and vCJD.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you normally resident in the UK? If No state country of usual residence</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Which countries have you visited in the last 12 months and what was the duration of stay?</p>	
<p>In the past 12 months have you been admitted to a hospital in a country other than the UK? If yes state when and which countries</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>In the past 12 months have you been admitted to another hospital in London or Manchester? If yes state when and which hospitals</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>List all current medications:</p>	

	Exclude if any regular prescribed drugs (except OCP)
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Is patient eligible to donate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No document reasons:	
If Yes proceed to screening tests Ensure consent for testing documented	
Sign and date (health care practitioner) to indicate patient has provided consent	

Obtain serology for:	Requested?
HIV antigen/antibody	<input type="checkbox"/> Yes
HTLV-1/HTLV-II antibodies	<input type="checkbox"/> Yes
Hepatitis A IgG (add on IgM if positive)	<input type="checkbox"/> Yes
Hepatitis B surface antigen	<input type="checkbox"/> Yes
Hepatitis C IgG	<input type="checkbox"/> Yes
Syphilis serology (T. pallidum antibodies)	<input type="checkbox"/> Yes
CMV IgG (add on IgM if positive)	<input type="checkbox"/> Yes
EBV Serology	<input type="checkbox"/> Yes
Strongyloides serology	<input type="checkbox"/> Yes

Provide stool sample collection pots and request forms x3 for patient to take home. Instruct patient to provide three separate samples over 2-3 days, ensuring the pot is filled halfway in order to complete all testing.

Stool testing for:	Requested?
Bacterial culture (Campylobacter, Salmonella, Shigella, E. coli O:157) x3	<input type="checkbox"/> Yes
Ova, Cysts and Parasites x3	<input type="checkbox"/> Yes
C. difficile	<input type="checkbox"/> Yes
Resistant Gram negative organism screen	<input type="checkbox"/> Yes
MRSA screen	<input type="checkbox"/> Yes
Helicobacter pylori stool antigen	<input type="checkbox"/> Yes
E. histolytica PCR (not orderable on PCR)	

Arrange follow up visit for a minimum of 2-3 weeks time

Follow-up visit

Serology results:	Result
HIV antigen/antibody	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected

HTLV-1/HTLV-II antibodies	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Hepatitis A IgG (add on IgM if positive)	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Hepatitis B surface antigen	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Hepatitis C IgG	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Syphilis serology (T. pallidum antibodies)	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
CMV IgG (add on IgM if positive)	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
EBV Serology	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Strongyloides serology	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected

Stool results:	Result
Bacterial culture (Campylobacter, Salmonella, Shigella, E. coli O:157) x3	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Ova, Cysts and Parasites x3	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
C. difficile	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Resistant Gram negative organism screen	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
MRSA screen	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
Helicobacter pylori stool antigen	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected
E. histolytica PCR (not orderable on PCR)	<input type="checkbox"/> Detected <input type="checkbox"/> Not detected

Is all testing complete?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accept as donor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any referrals required	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details of referrals made:	

Provide donor with stool collection kit x2 (contains collection instructions and copy of patient screening questionnaire 2). Explain requirement for stool to be fully processed within 6 hours of production.

The donor may provide multiple donations, but screening questionnaire 2 **MUST** be completed with **EACH** donation

If yes to any question, must undergo repeat full screening (however samples may be banked and quarantined for release after repeat testing).

If No to all questions samples may be released immediately and donor may continue to provide unlimited donations for 3 months after which time repeated screening will be required.