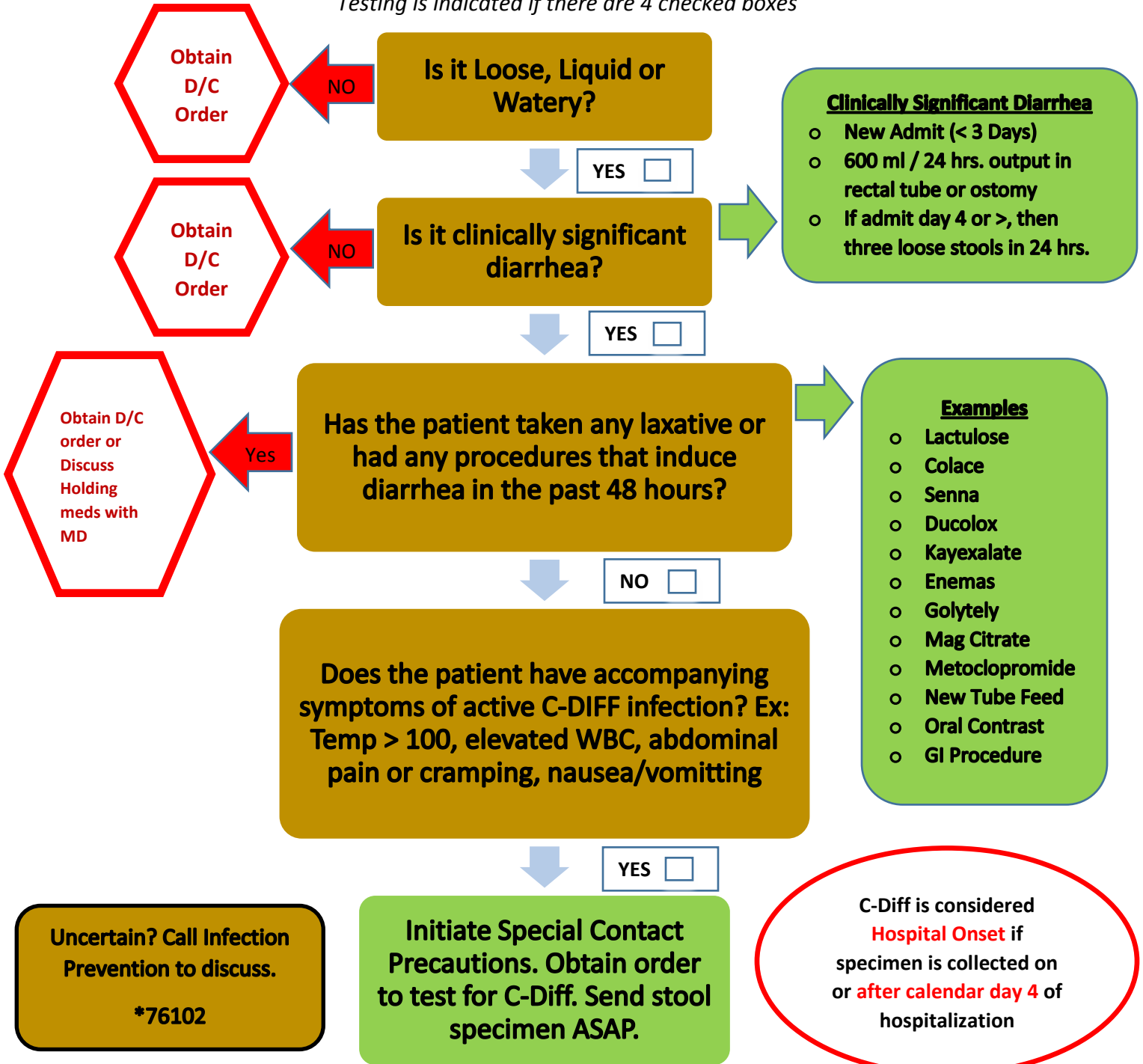


**Not a Permanent Part of Medical Record**

Checklist must be filled out and sent with all stools samples for

**Clostridium Difficile Testing**

Testing is indicated if there are 4 checked boxes



DO NOT RETEST FOR CURE

Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 RN (Print): \_\_\_\_\_  
 Please send this form to the Lab with the stool specimen.

Patient Label