




<b>Fæceslaboratoriet Aarhus Universitets</b> <b>Fæceslaboratoriet</b>	 midt regionmidtjylland
<b>FØLGESEDEL</b> Udskriftsdato: 15-07-2025 13:50:22	


**PATIENT:**

CPR.nr. (Stregkode): Navn:  Afdeling: <b>FMTRANDERS</b> <b>Fæces, Randers</b>
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**KOMPONENT:**

Tappenummer:	
Komponentkode:	
Komponent:	<b>Fæces Mikrobiota kapsler, frosne</b>

Obligatoriske smittetests er fundet negative  
**Bemærkninger vedr. anvendelse**

- Temperaturkrav <-80°C indtil brug
- Må ikke genfryses
- Fæceskomponent skal anvendes til denne patient

**Component and Faecal Microbiota Transplantation (FMT) information**

Number (capsule/mL)	Dose (g. faeces)	Expiry date (Storage at -80°C)	Expiry date (New date if stored at -20°C, 4 weeks)
Component issued/sent by	Date:	Name/Regional-ID:	
Component received by	Date:	Name/Regional-ID:	

**Completed during preparation and FMT-treatment**

Consent, only at the first FMT-treatment YES <input type="checkbox"/> NO <input type="checkbox"/>	FMT-date	FMT nr. in the current serial treatment of
Indication for FMT CDI <input type="checkbox"/> Other <input type="checkbox"/>	Component should be used before (time). (4 hours from thawing)	Pretreatment tab. Metoclopramid 10 mg? YES <input type="checkbox"/> NO <input type="checkbox"/>
Number of bowel movements: Past 24hours	Stool consistency the last 24 hours before FMT – Bristol stool scale 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 <input type="checkbox"/>	
Has the patient fasted prior to FMT? 6 hours fasting from food and dairy products YES <input type="checkbox"/> NO <input type="checkbox"/>	If NO, Number of fasting hours:	
For serial treatment: Complete only before the first FMT Pretreatment with antibiotics Vancomycin <input type="checkbox"/> Fidaxomicin <input type="checkbox"/> Other <input type="checkbox"/> : _____	Start date: _____ End date: _____ None <input type="checkbox"/>	Treatet with other antibiotics not related to the FMT treatment YES <input type="checkbox"/> NO <input type="checkbox"/>
FMT-treatment Initiation, time: _____ Termination, time: _____	Number of capsules ingested:	

**FMT method – Procedure code BIXY +**

Capsule <input type="checkbox"/> + BZAJ0	Colonoscopy <input type="checkbox"/> + KUJF32	Tube: Bengmark <input type="checkbox"/> + BIAD0	PEG <input type="checkbox"/> + BIAD5	Naso Gastric <input type="checkbox"/> + BIAD1	Rectal <input type="checkbox"/> + BIAD7
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Notes:

FMT conducted by	Date:	Name/Regional-ID:
Prescribing physician	Date:	Name/Regional-ID: