DICE Study055 Plate #010 Visit #000

Patient ID 1 Patient Initials F L Date of Study Day 201 (dd/mm/yyyy)

BASELINE Form

dd/mm/yyyy

1. **Study hospital admit date** 201
2. **Study ICU admit date** 201
3. **Sex:** ☐ female ☐ male
4. **Intubation date** 201 ☐ **N/A patient not intubated**
5. **Date of birth**
6. **Height** ☐ cm ☐ inches
7. **Actual weight (ICU admission)** ☐ kg ☐ lbs

8. **APACHE II Score** (first 24 hours in study ICU): **Admission diagnosis code:** (if admitted from OR or PARR code should be 48-85)

If "other" diagnosis code selected,specify: _____

9. **Location immediately prior to <u>this</u> ICU admission** (check ONE box):

- ☐ Emergency room
- ☐ Hospital ward
- ☐ Operating room /Recovery room
- ☐ ICU (other hospital), adm date:
- ☐ Emergency (other hospital), adm date:
- ☐ Ward (other hospital), adm date:
- ☐ Nursing home, adm date:

Other hospital admit date: dd/mm/yyyy 201

- ☐ Other (specify): _____

10. **Does the patient have any of the following based on chart review only?** (check ALL that apply):

- ☐ Celiac disease
- ☐ Irritable bowel syndrome
- ☐ Diabetes (T1DM/T2DM)
- ☐ Prior bowel resection surgery
- ☐ Prior *Clostridium Difficile* Infection
- ☐ Inflammatory bowel disease (Crohn disease, ulcerative colitis)
- ☐ Colectomy/Ileostomy
- ☐ Gastroparesis
- ☐ Chronic Pancreatitis
- ☐ Current *Clostridium Difficile* Infection
- ☐ Other _____
- ☐ None

DICE Study055 Plate #020

Study Day ☐☐

Patient ID ☐☐1☐☐☐ Patient Initials F ☐☐ L Date of Study Day ☐☐ ☐☐ 2☐1☐ (dd/mm/yyyy)

DAILY DATA FORM (page 1 of 4)

1. Advanced life support strategies received today

1. Invasive mechanical ventilation ☐ No ☐ Yes, if yes specify: ☐ ETT ☐ tracheostomy tube
2. Non-invasive mechanical ventilation (including CPAP/BiPAP for any duration, e.g., nocturnal) ☐ No ☐ Yes, if yes specify: ☐ CPAP ☐ BiPAP
3. Inotropes or vasopressor infusions (check all) ☐ No ☐ Yes

☐ dopamine ☐ norepinephrine ☐ phenylephrine ☐ milrinone
☐ dobutamine ☐ epinephrine ☐ vasopressin ☐ midodrine

4. Was dialysis performed today? ☐ No ☐ Yes, specify
☐ intermittent (IHD) ☐ continuous (CRRT) ☐ peritoneal ☐ other (specify):_____

2. Is this patient enrolled in the PROSPECT Pilot or RCT? ☐ No ☐ Yes

3. Laboratory results today (from AM Blood Work)

Leukocytes ☐☐☐☐☐.☐ ☐ x10^9/L ☐ mm^3
Hemoglobin ☐☐☐.☐ ☐ g/L ☐ g/dL
Platelets ☐☐☐☐☐☐ ☐ x10^9/L ☐ mm^3
Bicarb ☐☐ (mmol/L or mEq/L) ☐ < or ☐ >

Sodium ☐☐☐☐ (mmol/L or mEq/L)
Potassium ☐.☐ (mmol/L or mEq/L)
Chloride ☐☐☐☐ (mmol/L or mEq/L)
Creatinine ☐☐☐☐.☐ ☐ umol/L ☐ mg/dL

Albumin ☐☐.☐ ☐ g/L ☐ g/dL
Calcium ☐☐.☐☐☐ ☐ mmol/L ☐ mg/dL
Magnesium ☐.☐☐☐ ☐ mmol/L ☐ mg/dL
Phosphate ☐.☐☐☐ ☐ mmol/L ☐ mg/dL

4. Did the patient receive any nutrition today? ☐ No ☐ Yes, specify:

☐ Enteral Nutrition ☐ Trophic Feeds (defined as 10-20 mls/hr) ☐ Clear Fluids
☐ Diet as tolerated ☐ TPN ☐ Full Fluids

5. What activities were achieved today (Check ALL that apply)?

☐ Chest physio ☐ Up to chair ☐ Bike ☐ Bed exercises ☐ Ambulation ☐ None

6. Was a new antibiotic started today? ☐ No ☐ Yes

7. Was there a change in antibiotics today? ☐ No ☐ Yes

8. Were any of the following infections suspected today? ☐ **N/A, infections not specified.**

Respiratory Infection	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Blood stream infection	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Intra-abdominal infection	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Urinary tract infection	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
C difficile associated diarrhea	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Stool virology	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Other infection (e.g., meningitis, sinusitis) Please specify: _____	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	
Other infection (e.g., meningitis, sinusitis) Please specify: _____	☐ No	☐ Yes, was the culture positive?	☐ No	☐ Yes, spec: _____	

DICE Study055 Plate #021

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ Patient Initials F ☐ L ☐ Date of Study Day ☐☐ ☐☐ 2 0 1 ☐ (dd/mm/yyyy)

DAILY DATA FORM (page 2 of 4)

9. Did the patient receive any of the following?

1. H-2 receptor antagonist — ☐ No ☐ Yes
   If yes, specify: ☐ cimetidine (Tagamet) ☐ famotidine (Pepcid) ☐ other, specify: _____ ☐ ranitidine (Zantac) ☐ nizatidine (Axid)
   and specify: ☐ IV ☐ PO ☐ Both

2. Proton-pump inhibitor — ☐ No ☐ Yes
   If yes, specify: ☐ lansoprazole (Prevacid) ☐ esomeprazole (Nexium) ☐ dexlansoprazole (Dexilant) ☐ omeprazole (Losec) ☐ pantoprazole (e.g., Pantoloc, Tecta) ☐ rabeprazole (Pariet)
   and specify: ☐ IV ☐ PO ☐ Both

3. Motility agent — ☐ No ☐ Yes
   If yes, specify: ☐ domperidone (Motilium) ☐ metoclopramide (Maxeran) ☐ erythromycin
   Dose mg/24 hours ☐☐☐☐ Dose mg/24 hours ☐☐☐☐ Dose mg/24 hours ☐☐☐☐
   and specify ☐ other (specify) _____ Dose mg/24 hours ☐☐☐☐
   ☐ IV ☐ PO ☐ Both

4. Sorbitol/ Hyperosmolar agents — ☐ No ☐ Yes
   If yes, specify: ☐ Metformin ☐ Phenytoin ☐ Magnesium

5. Laxative, suppository or stool softener — ☐ No ☐ Yes
   If yes, specify: ☐ senna ☐ golytely ☐ lactulose ☐ colace ☐ citro-mag ☐ peglyte ☐ dulcolax ☐ glycerin ☐ other (specify) _____

6. Enema — ☐ No ☐ Yes
   If yes, specify number received and type: ☐☐ ☐ Fleet ☐ Soap suds ☐ Lactulose ☐ Milk and Molasses

7. Opiates — ☐ No ☐ Yes
   If yes, please complete the **Opiate Form**

8. Neuromuscular blockers — ☐ No ☐ Yes
   If yes, specify: ☐ rocuronium ☐ atracurium ☐ mivacurium ☐ vecuronium ☐ succinylcholine ☐ cisatracurium ☐ pancuronium

9. Probiotics — ☐ No ☐ Yes
   If yes, specify: ☐ Bio K ☐ Other, specify: _____ ☐ Lactobacillus

10. Chemotherapy agents (secreatory diarrhea) — ☐ No ☐ Yes
    If yes, specify: ☐ Cyclophosphamide ☐ Capecitabine ☐ Docetaxel ☐ Paclitaxel ☐ Methotrexate ☐ Cisplatin ☐ Doxorubicin ☐ Topotecan ☐ Interferon ☐ Cytosine ☐ 5-fluorouracil ☐ Lapatinib ☐ Rinotecan ☐ Daunorubicin ☐ Oxalipatin ☐ Other, specify: _____

11. Acetaminophen — ☐ No ☐ Yes
    If yes, specify: ☐ Suspension ☐ PO ☐ Both suspension and PO

DICE Study055 Plate #022

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ Patient Initials ☐☐ (F L) Date of Study Day ☐☐ ☐☐ (dd/mm/yyyy) 2 0 1 ☐

DAILY DATA FORM (page 3 of 4)

10. Did the patient receive any of the following antibiotics today (Please check ALL that apply)?

1. Beta Lactams — No ☐ Yes ☐ If yes, specify

- ☐ Penicillin G
- ☐ Penicillin V
- ☐ Ampicilin
- ☐ Ampicilin-Sulbactam
- ☐ Amoxicillin
- ☐ Amoxicillin-Clavulanate
- ☐ Piperacillin/Tazobactum
- ☐ Oxacillin
- ☐ Dicloxacillin
- ☐ Flucloxacillin
- ☐ Nafcillin
- ☐ Ticarcillin/Clavulanate
- ☐ Cloxacillan
- ☐ Not specified

2. Cephalosporins — No ☐ Yes ☐ If yes, specify

- ☐ Cefazolin
- ☐ Ceflexin (oral)
- ☐ Cefadroxil
- ☐ Cefuroxime
- ☐ Cefotiam
- ☐ Cefuroxime Cefepime
- ☐ Cefaclor (oral)
- ☐ Loracarbef
- ☐ Cefoxitin
- ☐ Cefotaxime
- ☐ Ceftriaxone
- ☐ Ceftazidime
- ☐ Cefepime
- ☐ Cefixime (oral)
- ☐ Cefpodoxime
- ☐ Cefdinir
- ☐ Proxetil (oral)
- ☐ Ceftibuten (oral)
- ☐ Ceftobiprole
- ☐ Ceftaroline
- ☐ Ceftazidime/Avibactam
- ☐ Ceftolozane/Tazobactam
- ☐ Not specified

3. Carbapenems — No ☐ Yes ☐ If yes, specify

- ☐ Imiperem
- ☐ Meropenem
- ☐ Ertapenem
- ☐ Doripenem
- ☐ Not specified

4. Aminoglycosides — No ☐ Yes ☐ If yes, specify

- ☐ Streptomycin
- ☐ Gentamicin
- ☐ Tobramycin
- ☐ Netilmicin/Amikacin
- ☐ Not specified

5. Quinolones — No ☐ Yes ☐ If yes, specify

- ☐ Norfloxin
- ☐ Enoxacin
- ☐ Ofloxacin
- ☐ Ciprofloxacin
- ☐ Levofloxacin
- ☐ Moxifloxacin
- ☐ Not specified

6. Tetracyclines — No ☐ Yes ☐ If yes, specify

- ☐ Tetracycline
- ☐ Doxycycline
- ☐ Minocycline
- ☐ Tigecycline
- ☐ Not specified

7. Nitromidazoles — No ☐ Yes ☐ If yes, specify

- ☐ Metronidazole (Flagyl) ► ☐ IV ☐ PO

8. Macrolides — No ☐ Yes ☐ If yes, specify

- ☐ Erythromycin
- ☐ Spiramycin
- ☐ Roxithromycin
- ☐ Clarythromycin
- ☐ Azithromycin
- ☐ Not specified

9. Lincosamides — No ☐ Yes ☐ If yes, specify

- ☐ Clindamycin

DICE Study055 Plate #023

Study Day

Patient ID 1

Patient Initials F L

Date of Study Day (dd/mm/yyyy) 2 0 1

DAILY DATA FORM (page 4 of 4)

10. Did the patient receive any of the following antibiotics today (Please check ALL that apply)? CONTINUED

10. Azole Derivatives — No ☐ Yes ☐ If yes, specify
- ☐ Miconazole
- ☐ Ketoconazole
- ☐ Fluconazole
- ☐ Itraconazole
- ☐ Voriconazole
- ☐ Posaconazole
- ☐ Amphotericin
- ☐ Clotrimazole
- ☐ Isavuconazonium
- ☐ Not specified

11. Echinocandins — No ☐ Yes ☐ If yes, specify
- ☐ Caspofungin
- ☐ Anidulafungin
- ☐ Micafungin
- ☐ Not specified

12. Glycopeptide — No ☐ Yes ☐ If yes, specify
- ☐ Vancomycin → ☐ IV ☐ PO ☐ PR
- ☐ Daptomycin

13. Monobactams — No ☐ Yes ☐ If yes, specify
- ☐ Aztreonam

14. Antivirals — No ☐ Yes ☐
- ☐ Trymethoprim/Sulfamethoxazole
- ☐ Rifampin
- ☐ Rifaximin
- ☐ Nitrofurantoin (Macrobid)
- ☐ Linezolid
- ☐ Fosfomycin
- ☐ Quinupristin/Dalfopristin
- ☐ Fidaxomicin
- ☐ Chlorhexidine
- ☐ Nystatin
- ☐ Other (specify):

15. Other — No ☐ Yes ☐ If yes, specify

16. Last day of study daily data collection?

- ☐ No
- ☐ Yes, patient died, was discharged to the ward, or study stopped at 70 days (submit **Final Status Form**)
- ☐ Yes, consent withdrawn for further data collection (submit a **Final Status Form**)

Study Day [ ][ ]

Patient ID [ ][ ] [1] [ ][ ][ ] Patient Initials [ ][ ] (F L) Date of Study Day (dd/mm/yyyy) [ ][ ] [ ][ ] [2][0][1][ ]

OPIATE & SEDATION FORM

1. Did the patient receive any of the following Opiods?

Drug	Route						Dose mg/24 hours
☐ Morphine	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Hydromorphone	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Percocet or Oxycodone	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Propofol	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Midazolam	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Diazepam	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Lorazepam	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ *Fentanyl	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ] *mcg in 24 hours
☐ Codeine (or tylenol #1,2 or 3)	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Demerol	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Methadone	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ *Dexemedetomidine	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ] *mcg in 24 hours
☐ Phenobarbitol	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Tramadol	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Other (specify): _______	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Other (specify): _______	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Other (specify): _______	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Other (specify): _______	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]
☐ Other (specify): _______	☐ Oral	☐ Bolus	☐ Infusion	☐ Subcut.	☐ Other spec. _______		[ ][ ][ ][ ][ ].[ ][ ]

DICE Study055 Plate #030

Study Day

Patient ID 1

Patient Initials (F L)

Date of Study Day (dd/mm/yyyy) 201

DIETICIAN FORM

1. Please specify the diet the patient is receiving today? (check all that apply)

- ☐ Clear fluids
- ☐ Full fluids
- ☐ Diet as tolerated
- ☐ Enteral nutrition
- ☐ TPN
- ☐ Unknown
- ☐ Other, specify: _____
- ☐ Trophic feeds
- ☐ NPO

2. What is the patients enteral nutrition target (target as determined by RD in total)? ☐☐☐☐ ☐ kcal ☐ mls/hr ☐ mls/ 24 hour ☐ Not specified

3. What percentage of the patients nutritional target did they receive? ☐☐☐ % ☐ Not specified

4. Were feeds interrupted? ☐ No ☐ Yes, specify

- ☐ High residuals
- ☐ Pre-procedure
- ☐ Vomiting
- ☐ Bleeding
- ☐ Ileus
- ☐ Aspiration
- ☐ Other, specify: _____
- ☐ Unknown

5. Is the patient receiving TPN?

☐ No ☐ Yes, specify

- ☐ Inadequate absorption (short bowel syndrome)
- ☐ Bowel obstruction
- ☐ Malnutrition
- ☐ Intra-abdominal Sepsis
- ☐ Gastrointestinal fistula
- ☐ Prolonged bowel rest
- ☐ Ileus
- ☐ Other, specify: _____

and specify what formulation:

- ☐ Peripheral/central starter formula
- ☐ Peripheral/central formula
- ☐ Central formula
- ☐ Volume restricted central formula
- ☐ Custom formula

and specify flow rate: ☐ 50 ☐ 85 ☐ 100 ☐ Other, specify: _____

and specify Total 24 hour volume: ☐ 1200 ☐ 2040 ☐ 2400 ☐ Other specify: _____

and specify lipid (intralipid) ☐ 50 ☐ 60 ☐ 85 ☐ Other specify: _____

6. Is the patient receiving free water? ☐ No ☐ Yes, specify how many mls in 24 hours ☐☐☐☐

DICE Study055 Plate #031

Study Day

Patient ID 1

Patient Initials (F L)

Date of Study Day (dd/mm/yyyy) 201

DIETICIAN FORM

7. Did the patient receive any enteral or oral nutrition today? ☐ No ☐ Yes, specify:

- ☐ Jevity 1.0 Cal (+ fibre)
- ☐ Jevity 1.2 Cal (+ fibre)
- ☐ Jevity 1.5 Cal (+ fibre)
- ☐ Nepro Carb Steady (1.8 kcal/mL + fibre)
- ☐ Nutren 1.5
- ☐ Peptamen 1.0
- ☐ NutriHep (1.5 kcal/mL)
- ☐ Promote (1.0 kcal/mL)
- ☐ Peptamen AF 1.2 Cal (fish-oils and prebiotics)
- ☐ Peptamen 1.5 Cal
- ☐ Isosource VHN (1.0 kcal/mL + fibre)
- ☐ Isosource VHP (1.0 kcal/mL)
- ☐ Isosource HN 1.2
- ☐ Isosource HN 1.2 (+ fibre)
- ☐ Isosource 1.5 (+ fibre)
- ☐ OXEPA (1.5 kcal/mL)
- ☐ Optimental 1.0 kcal/mL
- ☐ Glucerna 1.0 kcal/mL + fibre
- ☐ Resource 2.0
- ☐ Diabetic Resource 1.06 (+ fibre)
- ☐ TwoCal HN 2.0 (+ fibre)
- ☐ Novosource Renal 2.0
- ☐ Vital 1.0
- ☐ Replete
- ☐ Other, specify _____
- ☐ Ensure High Protein (1.0 kcal/mL)
- ☐ Ensure Plus Calories (1.5 kcal/ML)
- ☐ Oral (food) intake
- ☐ Oral (fluid) intake

volume not required

24h total ml of enteral nutrition delivered ☐☐☐☐☐

☐ Not applicable patient not receiving enteral nutrition

total enteral nutrition delivered ml/hr ☐☐☐☐

8. What is the feeding tube insertion site today? (check ALL that apply)

- ☐ Nasal
- ☐ Oral
- ☐ Percutaneous (specify:):
  - ☐ G tube
  - ☐ GJ tube
- ☐ Postpyloric
- ☐ No feeding tube in situ

DICE Study055

STOOL CLASSIFICATION FORM

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

WHO Classification of Diarrhea:

Diarrhea is defined as the passage of 3 or more liquid or loose stools per day

Stool Consistency Classification System (Adopted from Bliss *et al.* J. Wound Ostomy Contin. Nurs. 2001)

Hard and Formed	Soft but Formed	Loose & Unformed	Liquid
			
Having a hard or firm texture and retaining a definite shape like a banana, cigar or marbles	Retaining same general shape in the collection bag, does not spread all over the bottom of bag, or has a texture that appears like peanut butter	Lacking any shape of its own, spreads over the bottom of the collection bag; having a texture that appears like hot cereal	Like water

DICE Study055 Plate #040

Study Day

Patient ID 1

Patient Initials F L

Date of Study Day (dd/mm/yyyy) 201

STOOL CLASSIFICATION FORM

1. **Did the patient have a bowel movement today?** ☐ No ☐ Yes, please complete question 2-7
   ☐ Page not completed
2. **Did the patient have melena or hematochezia today?** ☐ No ☐ Yes
3. **Stool Classification:**

	Bristol Type 1-7	Bliss Score	Volume
Stool #1	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #2	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #3	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #4	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #5	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #6	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #7	☐	☐	smear ☐ medium ☐ small ☐ large ☐
Stool #8	☐	☐	smear ☐ medium ☐ small ☐ large ☐

☐ Check if more than 8 stools to be recorded for this study day (go to **Additional Stool Classification Form**)

☐ Not applicable, too watery or continuous
(At least 1 stool will need to be classified above)

4. **Were there any consequences of passing of stool today?** ☐ No ☐ Yes, specify
   ☐ Feeds held ☐ Stool softener held ☐ Rectal bag applied ☐ Other, specify
   ☐ Feeds changed ☐ Prokinetic held ☐ Rectal tube inserted _____
5. **Does the patient have any of the following in place?**
   ☐ Flexiseal ☐ Ileostomy ☐ Colostomy ☐☐☐☐ Volume (mL) ☐ None
6. **Any other changes to the patient's care today that you believe contributed to a change in the patient's bowel habits?** ☐ No ☐ Yes, specify _____
7. **Did the patients bowel habits meet the WHO Classification of Diarrhea today (3 or more liquid or loose stools)?** ☐ No ☐ Yes

DICE Study055 Plate #041

Study Day ☐☐

Patient ☐☐1☐☐☐ Patient ☐☐ (F L) Date of Study Day ☐☐ ☐☐ 2☐1☐ (dd/mm/yyyy)

ADDITIONAL STOOL CLASSIFICATION FORM

	Bristol Type 1-7	Bliss Score	Volume			
Stool #9	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #10	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #11	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #12	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #13	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #14	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #15	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #16	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #17	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #18	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #19	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #20	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #21	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #22	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #23	☐	☐	smear ☐	medium ☐	small ☐	large ☐
Stool #24	☐	☐	smear ☐	medium ☐	small ☐	large ☐

☐ Check if more stools are to be recorded for this study day (go to **Additional Stool Classification Form**)

DICE Study055 Plate #050

Study Day

Patient ID 1

Patient Initials (F L)

Date of Study Day (dd/mm/yyyy) 201

CLOSTRIDIUM DIFFICILE OUTCOME

Please submit a copy of all positive or indeterminante culture reports AND supporting clinical documentation (i.e., physician notes, nursing notes, laboratory results, radiology reports, clinical notes relating to stool, colonoscopy reports and histology reports if available)

1. *Clostridium difficile* associated diarrhea? ☐ No ☐ Yes, specify:

☐ ≥ 3 episodes of unformed stools in ≤24 hours

AND

☐ *Clostridium difficile* toxin positive stool

OR

☐ Colonscopic findings demonstrating pseudomembranous colitis

OR

☐ Histopathological findings of pseudomembranous colitis

2. Which test was this based upon? (Please check ALL that apply)

☐ ELISA (enzyme-linked immunosorbent assay) ☐ Other, please specify: _____

☐ PCR (polymerase chain reaction)

☐ LAMP (loop-mediated isothermal amplification)

☐ Cell Culture Cytotoxicity Assay

3. *Clostridium Difficile* Infection Severity (Clinical impression of Intensivist)

☐ Mild ☐ Moderate ☐ Severe (e.g., toxic mega-colon)

4. Were there any consequences of the *Clostridium difficile* infection today?

☐ Toxic megacolon ☐ Septic shock ☐ Other, specify _____

☐ Bowel perforation ☐ Colectomy ☐ NONE

DICE Study055 Plate #060

Study Day

Patient ID 1

Patient Initials (F L)

Date of Study Day (dd/mm/yyyy) 201

FINAL STATUS Form

1. **Was the patient discharged from the ICU alive?** ☐ No ☐ Yes
2. **Date of death or discharge from ICU** (dd/mm/yyyy) 201
3. **Was the patient discharged from the hospital alive?** ☐ No ☐ Yes ☐ Patient still in hospital at 1 year
4. **Date of death or discharge from hospital or if patient still hospitalized at 1 year, enter date 1 year from ICU discharge** (dd/mm/yyyy) 201
5. **Was the patient transferred to another hospital?** ☐ No ☐ Yes If yes, was it to a Long Term Care facility? ☐ No ☐ Yes