

FOOD AND WATERBORNE ILLNESS INVESTIGATION FORM

PATIENT INFORMATION

Surname:		First Name:		DOB (Y/M/D)		Male: <input type="checkbox"/> Female: <input type="checkbox"/>		Phone #: (h): (w):	
Home Address/Community			Daycare/School/Institution/Workplace:			Occupation:			
Guardian (if child):		Patient's Physician/Phone Number:			Diagnosis Date: Y: _____ M: _____ D: _____				
		Person Reporting:			Clinical _____ Lab _____				
Health Care #:	Hospitalized? Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Name of Hospital:			Admission Date (y/m/d):		Discharge Date (y/m/d):		

DISEASE INFORMATION

		SYMPTOMS	DURATION	SPECIMEN (stool/vomit/blood) COLLECTED:
AMOEBIASIS	<input type="checkbox"/>	VOMITING	<input type="checkbox"/>	Y: _____ M: _____ D: _____
BOTULISM	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	
CAMPYLOBACTER	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<u>TREATMENT PRESCRIBED:</u>
CRYPTOSPORIDIUM	<input type="checkbox"/>	Malaise	<input type="checkbox"/>	
E. COLI (VEROTOXIGENIC)	<input type="checkbox"/>	Cramps	<input type="checkbox"/>	
GIARDIA	<input type="checkbox"/>	Fever	<input type="checkbox"/>	
HEPATITS A	<input type="checkbox"/>	Chills	<input type="checkbox"/>	
NORWALK-LIKE VIRUS	<input type="checkbox"/>	Headache	<input type="checkbox"/>	
SALMONELLA	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	
SHIGELLA	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	
TRICHINOSIS	<input type="checkbox"/>	Dysphagia	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	
		Weight Loss	<input type="checkbox"/>	
		Other	<input type="checkbox"/>	

GENERAL ASSESSMENT INFORMATION

1. Contact of a previously diagnosed Case?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Name: Address:
2. Travel (including foreign travel and farm visits?)	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Location: Departed: Y: _____ M: _____ D: _____ Returned: Y: _____ M: _____ D: _____
3. Common Events/Feasts/Gatherings?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	List:
4. Contact with untreated water/milk	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	List:
5. Contact with animals? (home/farm/zoo)	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	List:
6. Hobbies & Recreation: (eg: hunting/fishing/camping)		List:
7. Other Medical Conditions (list):		

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FOOD HISTORY (FOODS CONSUMED DURING INCUBATION PERIOD WHICH WERE UNDERCOOKED, UNUSUAL OR SUSPECT)

SUSPECT FOOD	DATE EATEN (Y/M/D)	GIVE DETAILS OF PROBLEMS

NAME ALL CONTACTS (DURING INCUBATION PERIOD OF COMMUNICABILITY AND COMPLETE INVESTIGATION FORM ON ALL SYMPTOMATIC CONTACTS)

NAME (LAST, FIRST)	ADDRESS	PHONE	AGE	RELATIONSHIP TO CASE	ILL Y/N	COMMENTS/FOLLOW-UP (NOTE IF HIGH RISK)

*USE ADDITIONAL PAPER IF REQUIRED TO LIST ALL CONTACTS

HEALTH EDUCATION (AS APPLICABLE)

1. Disease	5. Avoid raw/cracked eggs	9. Sanitary disposal of human wastes
2. Handwashing	6. Protect cooked foods	10. Drinking untreated water (boil, treat)
3. Home food preparation	7. Cook all meat	11. Shellfish from approved source
4. Media Alert	8. Raw/unpasteurized milk	

COMMENTS:

DATE: _____ SUBMITTER'S SIGNATURE: _____

CRITERIA FOR EXCLUSION:

GIARDIA/OTHER ENTERIC	WHILE SYMPTOMATIC DAYCARE, SCHOOL, HEALTH CARE AND FOOD HANDLERS.
SHIGELLA, SALMONELLA TYPHI, SALMONELLA PARATYPHI	EXCLUSION FROM HIGH RISK LOCATION UNTIL 2 CONSECUTIVE STOOLS NEGATIVE AFTER CESSATION OF ANTIBIOTICS FOR 24 HOURS.
HEPATITIS A	EXCLUDE FROM DAYCARE, SCHOOL, HIGH RISK LOCATIONS FOR 14 DAYS FROM ONSET (7DAYS FROM JAUNDICE).