FOOD AND WATERBORNE ILLNESS INVESTIGATION FORM

PATIENT INFORMATION

Surname:	First Name:	DOB (Y/M/D)	Male: ☐ Female: ☐	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: ☐ No: ☐	Name of Hospital:	Admission Date (y/m/d):	Discharge Date (y/m/d):

DISEASE INFORMATION

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

GENERAL ASSESSMENT INFORMATION

1. Contact of a previously diagnosed Case?	Yes: ☐ No: ☐	Name: Address:
2. Travel (including foreign travel and farm visits?	Yes: ☐ No ☐	Location: Departed: Y:____ M:_____D:_____ Returned: Y: M: D:
3. Common Events/Feasts/Gatherings?	Yes: ☐ No: ☐	List:
4. Contact with untreated water/milk	Yes: ☐ No: ☐	List:
5. Contact with animals? (home/farm/zoo)	Yes: ☐ No: ☐	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 (7 DAYS FROM JAUNDICE).**

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