



**Washington State Department of Health
FOODBORNE ILLNESS INVESTIGATION FORM
PART I - CASE INVESTIGATION**

I. COMPLAINT INFORMATION										
Date of complaint ____/____/____		Complainant name			Address			(H) Phone		(C) Phone
Describe complaint, including name and location of food facility suspected to have caused illness:										
Name/Location of Facility: _____ Date of complaint meal: ____/____/____ Time of meal: _____										
II. CLINICAL DATA		PERSON NAME/CONTACT INFORMATION								
		Name: Phone: Address:		Name: Phone: Address:		Name: Phone: Address:		Name: Phone: Address:		
Was this person interviewed?		<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		
Age and sex		Age: _____ <input type="checkbox"/> M <input type="checkbox"/> F		Age: _____ <input type="checkbox"/> M <input type="checkbox"/> F		Age: _____ <input type="checkbox"/> M <input type="checkbox"/> F		Age: _____ <input type="checkbox"/> M <input type="checkbox"/> F		
I L L N E S S I N F O R M A T I O N	First symptom	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill		
	Date & time of first episode of vomiting or diarrhea	Date	Time	Date	Time	Date	Time	Date	Time	
	Date & time of last episode of vomiting or diarrhea	Date	Time	Date	Time	Date	Time	Date	Time	
	Duration of vomiting / diarrhea (circle hrs or days)	Hrs	Days	Hrs	Days	Hrs	Days	Hrs	Days	
	SYMPTOMS – circle correct answer (Y=yes, N=no, U=unknown)									
	Vomiting	Y	N	U	Y	N	U	Y	N	U
	Diarrhea	Y	N	U	Y	N	U	Y	N	U
	Avg # stools per day									
	Bloody diarrhea	Y	N	U	Y	N	U	Y	N	U
	Fever	Y	N	U	Y	N	U	Y	N	U
	Abdominal cramps	Y	N	U	Y	N	U	Y	N	U
	Body aches	Y	N	U	Y	N	U	Y	N	U
	Other (list)									
	ER visit	Y	N	U	Y	N	U	Y	N	U
	HCP visit	Y	N	U	Y	N	U	Y	N	U
	Hospitalization	Y	N	U	Y	N	U	Y	N	U
	Stool submitted	Y	N	U	Y	N	U	Y	N	U
	Lab results									
III. SUSPECTED FOOD OR ACTIVITY FOR A SINGLE CASE OF ILLNESS (SKIP TO SECTION IV IF > 1 PERSON ILL)										
For a <u>single case of illness</u> , record all food and drinks consumed in the incubation period of suspected agent/organism. If there is not enough information to categorize the suspect agent, record food and drinks consumed in the 72 hours prior to illness.										
Date: ____/____/____			Date: ____/____/____			Date: ____/____/____				
Brk: _____			Brk: _____			Brk: _____				
Lun: _____			Lun: _____			Lun: _____				
Din: _____			Din: _____			Din: _____				
Oth: _____			Oth: _____			Oth: _____				
Travel in the week prior to onset: <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____			Animal exposure in the week prior to onset: <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____			Contact with a person ill with vomiting or diarrhea in the week prior to onset: <input type="checkbox"/> Y <input type="checkbox"/> N				

COMPLETED BY (print): _____ Agency _____ Phone _____ Date ____/____/____

