ERIE COUNTY DEPARTMENT OF HEALTH
PUBLIC REPORT OF SUSPECTED FOODBORNE/WATERBORNE ILLNESS

NAME _____ DOB _____ AGE ____ SEX ____
Last First MI

ADDRESS _____

SS # _____ RACE ___ ETHNICITY___ PARENT NAME_____
(If pt. is a minor) Last First MI

HOME PHONE ( ) - _____ WORK PHONE ( ) - _____

Physician _____
Last First Address Phone

Origin of Referral _____
Referral Person Name Agency Name/Address Phone

Facility Name _____ Address _____ ? Eat In ? Carry Out

FOOD/WATER BORNE

Number of people at the meal? _____

Are any other people ill? _____

Was a physician consulted? _____ Yes _____ No

If YES, please list name & address _____

Have you received medication of any Kind? _____ Yes _____ No

If YES, what? (pills, shots, etc.?) _____

Approximately what date & time? _____

Were laboratory tests performed on: Vomitus Stool Blood Serum Date tested/performed: _____

Other: _____

Results: _____

Date and hour food eaten: _____

Did you become ill? ____Yes ____No How long did the illness last (hrs.)? _____

Onset Time: Date ____/____/____ Hour: _____A.M. or P.M. (incubation period_____)

Indicate any of the following conditions you have experienced:

Nausea	____	Fever (____°)	____	Chills	____	Sore Throat	____
Vomiting	____	Constipation	____	Dizziness	____	Cough	____
Diarrhea	____	Stomach Ache	____	Weakness	____	Headache	____
Thirst	____	Sweating	____	Cramps	____	Other	____

List food items at suspect meal:

_____

_____

_____

_____

Call Taken By: _____ Date _____

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