

# Massachusetts Department of Public Health FOODBORNE ILLNESS COMPLAINT WORKSHEET

<b>Date:</b> _____  <b>MAVEN ID#:</b> _____	<i>Please complete and fax to:</i> MDPH Food Protection Program 305 South Street Jamaica Plain, MA 02130 Fax: (617) 983-6770	<i>Questions?</i> Food Protection Program: (617) 983-6712 Division of Epidemiology: (617) 983-6800 Enteric Laboratory: (617) 983-6609
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## PERSON COMPLETING INFORMATION

<b>Affiliation:</b> <input type="checkbox"/> Local BOH <input type="checkbox"/> State <input type="checkbox"/> Other	<b>Name:</b> _____ <b>Town or DPH division:</b> _____ <b>Other, specify:</b> _____
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## REPORTER / COMPLAINANT

<b>Affiliation:</b> <input type="checkbox"/> Consumer <input type="checkbox"/> Medical provider <input type="checkbox"/> Laboratory <input type="checkbox"/> State DPH <input type="checkbox"/> Local BOH <input type="checkbox"/> Other  <b>Other, specify:</b> _____	<b>Name:</b> _____ <b>Phone:</b> _____ <b>Address:</b> _____  <b>Is complainant ill?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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## ILLNESS INFORMATION

<b># People ill:</b> _____ <b># People exposed:</b> _____	<b>Symptoms: (mark if reported <i>for anyone</i>):</b> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody stool <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Anorexia <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Chills <input type="checkbox"/> Nausea <input type="checkbox"/> Muscle aches <input type="checkbox"/> Burning in mouth <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Vomiting <input type="checkbox"/> Other symptoms: _____
<b>Duration:</b> <input type="checkbox"/> Less than 24 hours <input type="checkbox"/> Ongoing <input type="checkbox"/> 24 to 48 hours <input type="checkbox"/> Unknown <input type="checkbox"/> More than 48 hours	<b>Onset:</b> Earliest                      Date: _____                      Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Latest (if > 2 ill)                      Date: _____                      Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM

## ILL PERSONS

Name	Address & Town	Age	Occupation	Medical Provider Name & Phone	Stool Specimen	Diagnosis
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Incubation Periods for Selected Organisms

	Min	Max		Min	Max		Min	Max
B. cereus (short)	½ hr	6 hrs	Cyclospora	2 days	14 days	Shellfish poisoning	<1 hr	6 hrs
B. cereus (long)	6 hrs	24 hrs	E. coli	10 hrs	6 days	Staph aureus	½ hr	8 hrs
Campylobacter	2 days	5 days	Hepatitis A	15 days	50 days	Shigella	1 day	7 days
Calicivirus (norovirus)	12 hrs	48 hrs	Salmonella (non-Typhi)	6 hrs	72 hrs	Vibrio (non-cholera)	5 hrs	92 hrs
C. perfringens	6 hrs	24 hrs	Salmonella Typhi	3 days	60 days	Yersinia	1 day	14 days

**FOOD HISTORY**

Obtain food history back 72 hours prior to symptoms. If organism identified, obtain history for time period between minimum and maximum incubation periods. If more than two people are ill, follow the above time frame for common meals (foods) only. Always record time consumed, if possible; otherwise choose B= breakfast, L= lunch, D= dinner.

Suspect food or drink	Date & time consumed	Location consumed	Location purchased	Brand or Lot #	Food testing
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: _____ Time: _____ <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D	<input type="checkbox"/> Home <input type="checkbox"/> Where purchased <input type="checkbox"/> Other, specify: _____	Name: _____ Address: _____ City: _____ State: _____ Zip code: _____		Available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Sent to HSLI? <input type="checkbox"/> Yes <input type="checkbox"/> No