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| **Food and Drugs Authority**  **Foodborne Illness Reporting Form**  **(FDA/FSMD/FM-FBD/2012/01)** | | | | | | | | | | | | | | | | |
| Epid No: | | | | | *Please Complete and send or fax to:*  Food and Drugs Authority  P.O. Box CT 2783  Accra- Ghana  Fax:+233 302 229 794  Email: fda@fdaghana.gov.gh | | | | | | | *Questions? Call*  Food Safety Management Department  +233 302 233200  +233 302 235100 | | | | |
| Date: / /  dd mm yy | | | | |
| **A Patient/Client**  Surname:  First Name:  Middle Name:  Tel No: ( )  District: Community House No:  Occupation:  Age(yrs):  Age(months) :  Sex: Male Female  Suspected Food: Date Consumed: / / Time Consumed: Am Pm dd mm yy  Source of Food: School Canteen Office Canteen Restaurant Chopbar Street vended Food Home Event: (specify) Party Funeral Conference Other: | | | | | | | | | | | | | | | | |
| **B Illness Information**  **Symptoms:(***tick all applicable)*  Abdominal Cramps  Dehydration  Fever  Nausea  Bloody stool  Diarrhoea  Headache  Numbness  Chills  Dizziness  Jaundice  Vomiting  Convulsion  Excessive sweating  Muscle aches  Weakness  Other Symptoms:  Onset of Symptoms: Date: / / Time: Am Pm Duration **:** Less than 12hrs 12-24hrs More than 24hrs dd mm yy  Symptoms Ongoing: Yes No Did you seek medical attention? Yes No If yes, name of Health Facility:  Location Address: Date of visit to Health Facility:  ~~/~~  ~~/~~  dd mm yy Hospitalised: Yes No If yes, name of Physician: Contact No:  Laboratory test conducted: Yes No Type of sample: Agent Identified: | | | | | | | | | | | | | | | | |
| **C Food History** *Obtain history back 72hrs prior to symptoms.* | | | | | | | | | | | | | | | | |
| Date& Time B- Breakfast  L- Lunch  S- Supper | | | Total # persons (both ill and well) | | | | Food(s) consumed | | Source(s) of Food | | | | | Consumed at place purchased or received | | |
| B  0-24hrs    L    (Day 1)  S | | |  | | | |  | |  | | | | | Yes No      Yes  No      Yes  No | | |
| B  25-48hrs  L  (Day 2)  S | | |  | | | |  | |  | | | | | Yes No    Yes  No    Yes  No | | |
| 49-72hrs B  (Day 3)  L    S | | |  | | | |  | |  | | | | | Yes No    Yes  No    Yes  No | | |
| **Exposure History Within the Past 2 Months** | | | | | | | | | | | | | | | | |
| **International Travel?** Yes No | | | | | | **If yes,please specify countries:** | | | | | | | **Date of Departure:**  **Date of Arrival:** | | | |
| **Domestic Travel?** Yes No | | | | | | **If yes,please specify locations:** | | | | | | | **Date of Departure:**  **Date of Arrival:** | | | |
| **Contact with ill person?**Yes No  If yes, when:\_\_\_\_/\_\_\_\_/\_\_\_\_  dd mm yy | | | | | | **Please specify illness if known:** | | | | | | |  | | | |
| **Other persons in your household / community affected**  **No. of persons** **who ate implicated food:  No. affected:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Name of Affected Person** | **Tel. No** | **Date &Time** | **Age(yrs)/(months)** | | 1. |  |  |  |  | | 2. |  |  |  |  | | 3. |  |  |  |  | | 4. |  |  |  |  | | 5. |  |  |  |  | | 6. |  |  |  |  | | 7. |  |  |  |  | | 8. |  |  |  |  | | | | | | | | | | | | | | | | | |
| **D Food Sample Testing**    **Food(s) available for testing? Yes No Unknown**  **Laboratory test conducted? Yes**  **No** **Unknown** *If Yes, specify* food(s) & source(s)**:**    **Provide the following information if product/food is prepackaged or Commercially-processed**    Product name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Batch/lot #\_\_\_\_\_\_\_\_\_\_  Date of Manufacture:\_\_\_\_\_/\_\_\_\_\_ Expiration Date:\_\_\_\_\_/\_\_\_\_\_\_  mm yy mm yy  Package size (g,ml):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packaging Type:  Paper  Can  Plastic Other\_\_\_\_\_\_\_\_\_\_  Place of purchase: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Location address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. no.( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| For official use only Investigation Notes:          **Suspected Diagnosis: Confirmed Diagnosis:** | | | | | | | | | | | | | | | | |
| Investigated by: Signature: Date: | | | | | | | | | | | | | | | | |
| Incubation Periods for Selected Organisms | | | | | | | | | | | | | | | | |
|  | Min | Max | |  | | | | Min | | Max |  | | | | Min | Max |
| *B. cereus(short)* | 1hr | 6hrs | | *E. coli 0157:H7* | | | | 3days | | 8days | *Staph. aureus* | | | | 30min | 8hrs |
| *B. cereus(long)* | 6hrs | 24hrs | | *Hepatitis A* | | | | 15days | | 50days | *Shigella* | | | | 12hrs | 96hrs |
| *Campylobacter* | 1day | 10days | | *Salmonella (non-typhi)* | | | | 6hrs | | 72hrs | *Vibrio cholerae* | | | | 2hrs | 5days |
| *Cyclospora* | 1day | 14days | | *Salmonella typhi* | | | | 1wk | | 3wks | *Viral Gl* | | | | 12hrs | 48hrs |
| *C.pefringens* | 6hrs | 24hrs | | *Shellfish poisoning* | | | | Minutes | | few hr | *Yersinia* | | | | 3days | 7days |
| *Hepatitis E* | 3wks | 8wks | |  | | | | | | |  | | | | | |
| **E Person Completing Form**    **Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Tel No.:( ) Date of Completion of Form:**      **Name of Facility:** | | | | | | | | | | | | | | | | |