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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.  |   |   |   |   |

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|  **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:**  |