Food and Drugs Authority

Foodborne Illness Reporting Form

(FDA/FSM/FM-FBD/2019/01)

Epid No:___________
Yyyyyy

Date: qqqq / ____/ ____
dd mm yy

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

A Patient/Client

Surname: ____________ First Name: ____________ Tel No: ( ) ____________ Sex: Male ☑ Female ☐

Age(yrs): _____ District: ____________ Community ____________ Occupation: ____________

Marital Status: Single ☑ Married ☐

B Illness Information

Symptoms:(*tick all applicable*)

☐ Abdominal Cramps ☑ Bloody stool ☐ Chills ☐ Convulsion ☐ Dehydration ☐ Diarrhoea ☐ Dizziness ☐ Fever
☐ Excessive sweating ☐ Headache ☐ Jaundice ☐ Muscle aches ☐ Nausea ☐ Numbness ☐ Vomiting ☐ Weakness

Other Symptoms: ____________

Onset of Symptoms: Date: ____/ ____/____ (dd mm yy) Time: ________ Symptoms Ongoing: ☐ Yes ☐ No

If No, duration of Symptoms: ☐ Less than 12hrs ☐ 12-24hrs ☐ More than 24hrs

Have you sought medical attention elsewhere 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

Suspected Food: ____________ Date Consumed: ____/ ____/ ____ (dd mm yy) Time Consumed: ________

Source of Food: ☑ School Canteen ☐ Office Canteen ☐ Restaurant ☐ Chopbar ☐ Street vended Food ☐ Home
Event: (specify) ☐ Party ☐ Funeral ☐ Conference Other: ____________

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
0-24hrs (Day 1 ( ) B ( ) L ( ) S		Qwyyyyhh		☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
25-48hr Day 2 ( ) B ( ) L ( ) S				☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
49-72h (Day 3 ( ) B ( ) L ( ) S				☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

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.		• a		

4.				

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:**	

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: _____