Food and Drugs Authority

Foodborne Illness Reporting Form

(FDA/FSMD/FM-FBD/2012/01)

Epid No:__________ Date: ___/ ___/ ___ 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: __________ Middle Name: __________ Tel No: (   ) __________

District: __________ Community __________ House No: __________

Occupation: __________ Age(yrs): ____ Age(months) : ____ Sex: Male ☐ Female ☐

Suspected Food: __________ Date Consumed: ___/___/___ (dd mm yy) Time Consumed: ____ ☐Am ☐ Pm

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: ___/___/___ (dd mm yy) Time: ____ ☐Am ☐ Pm Duration: ☐Less than 12hrs ☐ 12-24hrs ☐More than 24hrs

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