ERIE COUNTY DEPARTMENT OF HEALTH
REFERRAL

☐ **FOOD/WATER BORNE**
☐ **OTHER**_____

NAME _____ DOB _____ AGE ____ ☐ Male ☐ Female
Last First MI

ADDRESS _____
City State Zip

SS # _____ RACE ___ ETHNICITY _____ PARENT(s) NAME _____
If pt. is a minor Last First MI

HOME PHONE ( ) _____ WORK PHONE ( ) _____

Physician _____
Last First Address Phone

Origin of Referral _____
Referral Person Name Agency Name/Address Phone

Facility Name _____ Address_____ ☐ Eat In? ☐ Carry Out?

FOOD/WATER BORNE

Number of people at the meal?_____

Are any other people ill? _____

Was a physician consulted? ☐ Yes ☐ No

- If YES, list name & address _____

Have you received medication of any Kind? ☐ Yes ☐ No

- If YES, what? (pills, shots, etc.?) _____
- Approximately what date & time? _____

Sensitive Situation:	☐ Yes	☐ No
Food handler	☐ Yes	☐ No
Day Care Worker	☐ Yes	☐ No
Day Care Attendee	☐ Yes	☐ No
Health Care Worker	☐ Yes	☐ No

If yes, where?_____

Were any laboratory tests performed on: ☐ Vomitus ☐ Stool ☐ Blood Serum Date tested/performed:_____

- Other:_____
- Results: _____

Food Eaten: Date _____ Time: _____ ☐ a.m. ☐ p.m.

Did you become ill? ☐ Yes ☐ No How long did the illness last? (hours) _____

Onset Time: Date ____/____/____ Time: _____ ☐ a.m. ☐ p.m. (incubation period_____)

Indicate any of the following conditions you have experienced:

☐ Nausea	☐ Fever _____ °	☐ Chills	☐ Sore Throat
☐ Vomiting	☐ Constipation	☐ Dizziness	☐ Cough
☐ Diarrhea	☐ Stomach Ache	☐ Weakness	☐ Headache
☐ Thirst	☐ Sweating	☐ Cramps	☐ Other _____

Contact with animals: ☐ Yes ☐ No ☐ Reptiles ☐ Live Poultry

BELOW IS A LIST OF FOOD AND BEVERAGES SERVED AT THE SUSPECT MEAL
Check only those which you consumed/ate

Food Item		Food Item		Food Item		Food Item	

Call Taken By: _____ Date _____