

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:

- | | | | |
|-----------------------------------|--|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Fever _____ ° | <input type="checkbox"/> Chills | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Ache | <input type="checkbox"/> Weakness | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Thirst | <input type="checkbox"/> Sweating | <input type="checkbox"/> Cramps | <input type="checkbox"/> 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 _____