**FOODBORNE ILLNESS INVESTIGATION**

INITIAL CASE REPORT FORM

To be filled by the reporting medical establishment by treating physician or infection control staff Report within 24 hours even if laboratory report is pending

# 1. Report

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | | |
| Hospital / Establishment: |  | | |
| Physician's Name: |  | | |
| Designation: |  |  |  |
| Contact Number(s): |  |  |  |
| Email address: |  |  |  |

# 2. Patient Identification

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| I. D. Number |  | | |
| Date of Birth |  | | |
| Sex |  | Male Female |  |
| City: |  |  |  |
| Contact Number(s): |  |  |  |

# 3. Illness Information

|  |  |  |
| --- | --- | --- |
| Date Person Became Ill |  | Time: 􀂅 AM |
| Time: 􀂅 PM |
| Time Of Attendance To The Clinic |  | Time: 􀂅 AM |
| Time: 􀂅 PM |
| Time Of Hospitalization (if applicable) |  | Time: 􀂅 AM |
| Time: 􀂅 PM |

# 4. Symptoms Reported:

|  |  |  |  |
| --- | --- | --- | --- |
| Vomiting |  | Nausea |  |
| Diarrhea |  | Abdominal pain |  |
| Fever |  | Blood in stools |  |
| Headache |  | Muscle aches |  |
| Fatigue |  | Dizziness |  |
| Loss of appetite |  | Chills |  |

# 5. Description of the course of Illness:

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

# 6. Laboratory

# Name of Laboratory

# Samples Collected? Yes No

Stool Vomitus Other Sample (specify):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date | Month | Year |
| Sample Collected On: |  |  |  |
| Received in Laboratory On |  |  |  |
| Date of Results |  |  |  |
| Final Test Report |  | | |

# 7. Diagnosis:

A. Suspected food poisoning: (Clinical case)

B. Confirmed food poisoning: (By Laboratory)

C. Other:

|  |
| --- |
|  |
|  |
|  |

# 8. Meal History (add separate list if more space is required)

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | | Place dining  At home/outside |
| Day 1 | Food | Time |
|  |  |  |  |
|  |  |  |
|  |  |  |
| Date |  | | Place dining  At home/outside |
| Day 2 | Food | Time |
|  |  |  |  |
|  |  |  |
|  |  |  |
| Date |  | | Place dining  At home/outside |
| Day 3 | Food | Time |
|  |  |  |  |
|  |  |  |
|  |  |  |

**9. List of persons who attended the same event and shared the same meal**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| No | Nam | Age | Sex | Nationality | Ill | Well | Contact  Number |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |

**10. Conclusion**

Needs further investigation by outbreak team as suspected / confirmed Outbreak

Single Case Report. Needs no further action.

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Signature of Treating / Reporting Physician

**N.B. please submit the completed form to** [**foodpoisoning@dm.gov.ae**](mailto:foodpoisoning@dm.gov.ae)