



Department of
Health

FoodNet Case Report Form

The FoodNet Case Report Form should be used for **Campylobacter, Cryptosporidium, Cyclospora, Listeria, Shigella, STEC, Vibrio and Yersinia**. Please fill this form out as complete as possible.
Do not forget to complete the appropriate disease-specific supplemental form.

Last Name: _____ First: _____ Middle: _____ DOB: _____
PSN1 _____ TN01 CAS1 _____ TN01 State Lab Accession #: _____

FOR ADMINISTRATIVE USE

FoodNet Case? ☐ Yes ☐ No ☐ Unknown
Was the case found during an audit?* ☐ Yes ☐ No ☐ Unknown **FoodNet hospital visits constitutes an audit.**
Was the case interviewed by public health? ☐ Yes ☐ No ☐ Unknown
If no, was an attempt made? ☐ Yes ☐ No ☐ Unknown
Interviewer's Name: _____
Was an exposure history obtained? ☐ Yes ☐ No ☐ Unknown
Date of first attempt: _____
Date of Interview: _____

DEMOGRAPHICS

Reported Age: _____ ☐ Days ☐ Months ☐ Years Sex: ☐ Male ☐ Female ☐ Unknown
Street Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Did patient immigrate to the US within 7 days of specimen collection? ☐ Yes ☐ No ☐ Unknown
In the past 7 days, has the patient lived/stayed overnight in any of the following locations? (check all that apply)
☐ Dormitory ☐ Long-term Care Facility/Rehabilitation Center ☐ Homeless Shelter ☐ Outdoors/Other structure not intended for housing
☐ Correctional Facility ☐ Other Communal Living: _____ ☐ None of the above ☐ Unknown
Ethnicity: ☐ Hispanic Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ White
☐ Not Hispanic ☐ Hawaiian / Pacific Islander ☐ Refused ☐ Other: _____
Employer/School: _____ Occupation: _____
Is this patient associated with a daycare facility? ☐ Yes ☐ No ☐ Unknown
If yes, specify association: ☐ Attend daycare ☐ Work/volunteer at daycare ☐ Live with daycare attendee
If yes, name of daycare: _____
Is this patient a food handler? ☐ Yes ☐ No ☐ Unknown
If yes, name of restaurant/facility: _____

LAB REPORT

Reporting Facility: _____ Ordering Facility: _____
Ordering Provider: _____ Phone Number: _____
Jurisdiction: ☐ East Tennessee ☐ Mid-Cumberland ☐ Northeast ☐ South Central ☐ Southeast
☐ West Tennessee ☐ Upper Cumberland ☐ Nashville/Davidson ☐ Chattanooga/Hamilton ☐ Knox/Knoxville
☐ Jackson/Madison ☐ Memphis/Shelby ☐ Sullivan ☐ Out of Tennessee ☐ Unassigned
Specimen Source: ☐ Blood ☐ CSF ☐ Stool
☐ Urine ☐ Unknown ☐ Other _____

Lab Report Date: _____	ORGANISM IDENTIFIED	TEST TYPE(S)	CASE STATUS
Date Received by Public Health: _____	<input type="checkbox"/> Campylobacter <input type="checkbox"/> Cryptosporidium	<input type="checkbox"/> Culture	<input type="checkbox"/> Confirmed
Date Specimen Collected: _____	<input type="checkbox"/> Cyclospora <input type="checkbox"/> Listeria <input type="checkbox"/> Shigella	<input type="checkbox"/> PCR	<input type="checkbox"/> Probable
	<input type="checkbox"/> STEC <input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia	<input type="checkbox"/> EIA	<input type="checkbox"/> Suspect
		<input type="checkbox"/> Other: _____	

OUTBREAK/CLUSTER

Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown CDC Cluster Code: _____
Type of Outbreak: _____ CDC EFORS/NORS Number: _____
☐ Animal Contact ☐ Environmental Contamination Other than Food/Water ☐ Foodborne
☐ Indeterminate ☐ Person-to-Person ☐ Waterborne
☐ Other: _____

INVESTIGATION			
Investigation Start Date: _____		Investigator: _____	
Investigation Status: <input type="checkbox"/> Open <input type="checkbox"/> Closed		Date Assigned to Investigation: _____	
SYMPTOM HISTORY			
Date of Illness Onset: _____		First Symptom: _____	
Symptoms: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody Diarrhea <input type="checkbox"/> Constipation <i>Check all that apply</i> <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Fever (Max Temp: _____ °F) <input type="checkbox"/> Headache <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Other: _____			
If yes to diarrhea, date of diarrhea onset: _____			
If yes to vomiting, date of vomiting onset: _____			
As of today, are you still experiencing symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If recovered, date of recovery: _____			
Duration of Illness: _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days			
CLINICAL INFORMATION/HOSPITALIZATION			
Was the patient hospitalized for this illness?		If yes, Hospital Name: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Admission Date: _____	
		Discharge Date: _____	
Was the patient <u>transferred</u> from one hospital to another?		If yes, specify the hospital to which the patient was transferred:	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		_____	
Was there a second hospitalization?		If yes, Hospital Name: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Admission Date: _____	
		Discharge Date: _____	
During any part of the hospitalization, did the patient stay in and Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Did the patient die from this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
TRAVEL HISTORY			
Did the patient travel prior to the onset of illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Type	Destination	Date of Arrival	Date of Departure
<input type="checkbox"/> Domestic <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> International			
Notes:			
RELATED CASES			
Does the patient know of any similarly ill persons (with diarrhea)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Are there any other cases related to this one? <input type="checkbox"/> Yes, household <input type="checkbox"/> Yes, outbreak <input type="checkbox"/> No, sporadic <input type="checkbox"/> Unknown			
If yes, did the health department collect contact information about other similarly ill persons to investigate further?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Provide names, onset dates, contact information and any other details for similarly ill persons or related cases:			

Shiga Toxin - Producing Escherichia coli (STEC) Case Report Form

Last Name: _____ First: _____ DOB: _____

PSN1 _____ TN01 CAS1 _____ TN01 State Lab Accession #: _____

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

These questions are about exposures you may have had in the 7 days before you got sick. There are questions about various items, including animals, ill persons, water, special diets, special events, and various foods you may have come into contact with. For each of the questions, please answer yes, no, or may have.

ANIMAL CONTACT — In the 7 days before illness...					Yes	No	May Have	Did Not Ask/Answer
1. Did you work at, live on, or visit a farm, ranch, fair or petting zoo with animals? (circle which setting)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1A. Where? _____ When? _____								
2. Did you come into contact with any...					Yes	No	May Have	Did Not Ask/Answer
Cats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dogs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chicken/turkey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Birds (non-poultry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Other: _____								
2A. Where did you come into contact with the animal(s)? _____ When? _____					Yes	No	May Have	Did Not Ask/Answer
3. Did you come into any contact with animal feces or manure?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you come into contact with a pet that had diarrhea?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you have any contact with dry, canned, or frozen animal feed?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5A. Please describe: _____								
PERSON-TO-PERSON								
1. Did one of your household members or another person you spend a lot of time with have diarrhea in the 7 days before you became ill?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1A. Who? _____ Where? _____								
2. Did you work at, live in, or visit a residential facility or institution? (jail, nursing home, daycare, etc.)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2A. Where? _____ When? _____								
WATER								
1. Do you use water from a private well as your primary source of drinking water?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did you drink any water directly from a natural spring, lake, pond, stream, or river in the 7 days before illness?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you swim or wade in water from a natural setting (lake, river, pond, ocean, etc.) in the 7 days before illness?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3A. Where? _____ When? _____								
4. Did you swim or wade in treated/chlorinated water (pool, hot tub, waterpark, fountain, etc.) 7 days before illness?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4A. Where? _____ When? _____								
FOOD PREFERENCES								
1. Are you a vegetarian or vegan?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Before you became ill, were you on a special diet for medical, weight loss, religious, allergies or any other reason?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2A. Please describe: _____								
EVENTS/ RESTAURANTS — In the 7 days before illness...								
1. Did you attend any special events/group meals? (concerts, festivals, sporting events, religious gatherings, etc.)					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1A. What event(s)? _____ Where? _____ When? _____								
2. Did you eat food prepared outside the home (restaurants, catered events, etc.)?					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2A. If yes or maybe ate out, which setting? (check all that apply)								
<input type="checkbox"/> Fast-food (order at counter) <input type="checkbox"/> Take-out or delivery food <input type="checkbox"/> Bakery <input type="checkbox"/> Other: _____								
<input type="checkbox"/> Sit-down restaurant (order taken at table) <input type="checkbox"/> Catered event <input type="checkbox"/> Ice cream or dessert shop								
<input type="checkbox"/> Self-serve buffet <input type="checkbox"/> School or other institutional setting <input type="checkbox"/> Coffee or tea shop								
2B. Name(s) and Address(es):		Foods eaten:			When?			

These next questions are about where your food at home came from in the 7 days before you became ill.

SOURCES OF FOOD AT HOME

<i>Did your food come from...</i>	Yes	No	May Have	Did Not Ask/Answer	Name(s) and Location(s)
1. Grocery stores/supermarkets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Warehouse stores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Small markets/mini-marts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Health food, "whole food" stores, co-ops?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Farmer's markets, roadside stands, farm? (including farm shares, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

The next section is about specific foods you may have eaten, grouped by category. For each food item, please answer yes, no, or may have eaten. The first category is meats, which includes whole meats or meats on a salad, sandwich, or in a prepared dish, etc.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
MEAT						
1. Any beef or foods containing beef?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1A. Ground beef at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1B. Ground beef purchased as patties ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1C. Undercooked or raw ground beef at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1D. Steak or roast beef at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Did you or anyone in your household handle raw beef?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Any pork or foods containing pork? (including deli meat, sausage, bacon, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Any bison ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Any wild game ? (venison, elk, boar, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Any dried meats? (jerky, pepperoni, salami, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Any other meats? (processed meats, hotdogs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about dairy products.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
DAIRY						
1. Pasteurized ("regular") milk? (including goat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Raw or unpasteurized milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Yogurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ice cream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Cheese? (block, shredded, sliced, string cheese, cottage cheese, feta, parmesan, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5A. Artisanal or gourmet cheeses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5B. Soft cheese? (queso fresco, brie, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5C. Soft cheese made from raw milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5D. Other raw milk cheeses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Other unpasteurized dairy products? (yogurt, ice cream, etc. made from raw milk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Other dairy products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about fresh, raw vegetables unless otherwise specified. This includes vegetables that are whole, cut/chopped, or a component of another food item.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
VEGETABLES						
1. Lettuce? (in a salad, on a sandwich, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1A. Iceberg lettuce at home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1B. Bagged or prepackaged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1C. Iceberg lettuce outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1D. Romaine lettuce at home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1E. Bagged or prepackaged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1F. Romaine lettuce outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Spinach? (in a salad, on a sandwich, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2A. Spinach at home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2B. Bagged or prepackaged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2C. Spinach outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Other greens? (arugula, kale, mesclun, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Sprouts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4A. Did you handle any sprouts, even if you didn't eat them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Green onion / Scallions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Fresh (not dried) herbs? (basil, cilantro, parsley, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about nuts and seeds.

NUTS AND SEEDS						
<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
1. Peanuts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Almonds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Cashews?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Pistachios?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Hazelnuts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Mixed nuts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7. Other nuts? (pine nuts, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Peanut butter or foods containing peanut butter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
9. Other nut butter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10. Any seeds? (sunflower, sesame, chia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11. Trail mix?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12. Hummus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about additional food exposures.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
OTHER FOODS						
1. Any foods marketed for babies? (formula, store-bought baby food, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Any powdered shake or meal products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Any raw or unpasteurized juice or cider? (sometimes bought from a farm or orchard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Other foods that feel relevant that have not already been covered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

This is the end of the food and exposure specific questions.

	Yes	No	May Have	Did Not Ask/Answer	Comments/Notes
OTHER COMMENTS					
1. Has the patient been diagnosed with HUS/TTP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there anything else you feel may be relevant that has not already been asked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

FOR INTERVIEWER USE

At the conclusion of the interview please...

- Answer any questions
- Thank the patient for their time
- Provide hygiene and prevention education
- Notify the appropriate staff of potential outbreaks, events, or unusual information
- Exclude persons from sensitive populations until 48 hours symptom free (health/day care, food handler)
- **FoodCORE staff:** contact regional/ local health department for exclusions

INTERVIEWER COMMENTS