

Food Safety Program PO Box 1163 Richmond, VA 23218 804-786-3520

Foodborne Illness Complaint Report

Complaint Information
Firm Name:
Firm Address:
Firm ID:
Date Complaint Received: Time Complaint Received:
Received By: Choose an item.
Received From: Public Receipt Method: Choose an item.
Complaint Type: Illness Confirmed Illness Unconfirmed
Assigned to: Choose an item. Investigate Within: Choose an item.
Complainant Information
Complainant information
Anonymous:
Name of Complainant:
Address of Complainant (if applicable for Service Samples):
Phone Number of Complainant: Email Address for Complainant:
Complaint Details
Nature of Complaint:
Product Category: Choose an item.
Specific Product:
Date Product Purchased:
Container Type: Choose an item.

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Container Size:				
Package/Container Code:				
Manufacturer Name:				
Manufacturer Address:				
Complaint Location (if complai	nt not associated with a firm)			
Address: Directions to property:				
Demographic Information: Gender: Choose an item.				
Occupation:	Age:			
Others in party ate the same food(s)? Choose an item.				
Family or friends that have been ill with similar symptoms? Choose an item.				
Suspect Food and Beverages Consumed				
Suspect Meal:				
Date suspected meal was consumed: Time suspected meal was consumed:				
Location:				
Take Out? Choose an item.				
If take out, how long after the	order was placed was the food picked up (minutes):			
Date purchased:	Time Purchased:			
Description of Meal:				
Food/Beverage History (Repea	nt for as many meals as possible)			
Date Consumed:	Meal Type: Choose an item.			
Foods Consumed:				
Locations:				
Date Consumed:	Meal Type: Choose an item.			
Foods Consumed:				
Locations:				
Date Consumed:	Meal Type: Choose an item.			
Foods Consumed:				

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Locations:					
Date Consumed:	Meal Type: Choos	e an ite	em.		
Foods Consumed:					
Locations:					
Symptoms Onset of symptoms Date:	Onset of sympto	ms Tim	e:		
Symptoms experienced (check all that	at apply):				
Vomiting Muscle Aches Headache Burning Mouth Other	Diarrhea Chills Cough Itching		Nausea Cramps Perspiration Rash		Fever Excessive Salivation Metallic Taste Numbness
Which symptom above is most preva	alent?				
Medical Treatment Did they seek medical treatment? Ch	noose an item.		If yes, where: Choose	an ite	m.
Were they hospitalized? Choose an If yes, hospital name and add					
Doctor Name:					
Hospital Phone:					
Cultures/Samples: Choose an item.	Date Cult	ures/S	amples Submitted:		
Results of Specimens:					
Result Date:					
Medical Diagnosis: Treated with Medications? Choose a	an item.				
Water Source Home: Choose an item.					
Name:					
Work: Choose an item.					
Name:					

Have you been exposed to other water sources in the past 6 weeks (i.e.	swimming, bathing, o	drinking, brushing teeth,
consuming, ice etc.)? Choose an item.		

If yes, provide details on type of water exposed to:

Investigation Details (to be completed by inspector)

Investigated By: Choose an item. Investigation Date:

Activity: Choose an item. Food Process Evaluated: Choose an item.

If other, describe:

Sample Taken: Choose an item. If YES, Sample Number:

Investigation Nature				
Investigation Notes:				
Time Spent (hours):				
Confirmed Valid: Choose an item.	*Contributing Factor: Choose an item. If other, describe:			
Intentional Food Contamination: NO	Status: Choose an item.			
If Referred, state who complaint was referred to:				
*Required only when Confirmed Valid is selected as YES				