VIRGINIA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

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

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.

Container Size:

Package/Container Code:

Manufacturer Name:

Manufacturer Address:

Complaint Location (if complaint 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 (Repeat 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:

Locations:

Date Consumed: **Meal Type:** Choose an item.

Foods Consumed:

Locations:

Symptoms

Onset of symptoms Date: **Onset of symptoms Time:**

Symptoms experienced (check all that apply):

☐ Vomiting	☐ Diarrhea	☐ Nausea	☐ Fever
☐ Muscle Aches	☐ Chills	☐ Cramps	☐ Excessive Salivation
☐ Headache	☐ Cough	☐ Perspiration	☐ Metallic Taste
☐ Burning Mouth	☐ Itching	☐ Rash	☐ Numbness
☐ Other			

Which symptom above is most prevalent?

Medical Treatment

Did they seek medical treatment? Choose an item. **If yes, where:** Choose an item.

Were they hospitalized? Choose an item.

If yes, hospital name and address:

Doctor Name:

Hospital Phone:

Cultures/Samples: Choose an item. **Date Cultures/Samples Submitted:**

Results of Specimens:

Result Date:

Medical Diagnosis:

Treated with Medications? Choose 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, 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 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**