Foodborne Disease Reporting Form

(form can be used to report Amebiasis, *Campylobacter* spp., *Cryptosporidium* spp., *Cyclospora* spp., *E. coli* infection, *Giardia*, *Listeria* spp., *Salmonella* spp., *Shigella* spp., Trichinosis, *Vibrio* spp., *Yersinia* spp.)

› Disease Specific Information

Disease Name: _____ Onset date: _____ Reporting date: ___ / ___ / _____

› Patient Demographic Information

Last name: _____ First name: _____ Middle name: _____

Date of birth: ___ / ___ / _____ Patient age: _____ Medical record #:_____

Preferred Language: ☐ English ☐ Other: _____

Country of birth: ☐ United States ☐ Other: _____ ☐ Unknown

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Unknown

Address: _____ County: _____

City:_____ State: ____ Zip: _____ ☐ Address unknown ☐ Homeless

Phone:_____ Alternate phone: _____

Occupation: _____ Parent/guardian name: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply): ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Black/African American ☐ Unknown ☐ Other: _____

› Hospital/Clinic Information

Reporter name:_____ Reporting institution:_____

Ordering provider: _____ Provider phone: _____

Lab: _____ Lab phone: _____

Who should MDH contact if additional information is needed:

☐ Reporter ☐ Provider ☐ Lab ☐ Other:_____

Specimen collection date:_____ Specimen source:_____

Lab result date: _____

Hospitalized: ☐ Yes ☐ No ☐Unknown If yes, admit date: ___ / ___ / _____

Hospital name: _____ Discharge date: ___ / ___ / _____

Died: ☐ Yes ☐ No If yes, date of death: _____

Pregnant (if applicable): ☐ No ☐ Yes, due date: ___ / ___ / _____

› Foodborne Disease Specific Information

Foodhandler: ☐ Yes ☐ No ☐ Unknown If yes, restaurant name: _____

Childcare attendee/worker: ☐ Yes ☐ No ☐ Unknown If yes, childcare center name: _____

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown If yes, antibiotic name:_____

Antibiotic treatment date: ___ / ___ / _____

Did the patient travel outside the United States one week prior to illness onset: ☐ Yes ☐ No ☐ Unknown

Did the patient develop hemolytic uremic syndrome (HUS): ☐ Yes ☐ No ☐ Unknown (If yes, please complete HUS form)

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