STATE OF FLORIDA
DEPARTMENT OF HEALTH

PRODUCT COMPLAINT INCIDENT

Client Name __________ Address __________
Phone (Home) __________ (Business) __________ Date __________
Location of Outbreak __________ Date of Exposure __________
Number of Persons Exposed __________ Number of Persons Made Ill __________
Onset Date/Time of Illness __________ Incubation Time __________

Symptoms of Illness (Please check) :

[ ] Nausea [ ] Vomiting [ ] Abdominal pain / cramps [ ] Soapy / salty taste
[ ] Diarrhea [ ] Metallic Taste [ ] Burning of lips, mouth [ ] Numbness of mouth
[ ] Headache [ ] Dizziness [ ] Bloody or black stools [ ] Fever _____ ^{0} F
[ ] Other __________ Was physician seen [ ] Yes [ ] No

DOCUMENTATION OF PHYSICIAN'S VISIT SHOULD BE SUBMITTED WITH REPORT.

What foods were eaten? __________
Source of food? __________
Sample collected by: __________
Sample Lot # __________
Control Lot # __________

Examination [ ] Visual exam __________
[ ] Source of contamination unknown

BACTERIOLOGICAL (Please check test requested) :

[ ] Fecal Coliform __________ [ ] Standard Plate Count (SPC) __________
[ ] Salmonella __________ [ ] Fecal Streptococcus __________
[ ] C. perfringens __________ [ ] Coagulase Positive Staphylococcus/toxin __________
[ ] B. cereus/toxin __________ [ ] Other __________

CHEMICAL (Please check test requested) :

[ ] Heavy metals screen __________ Pesticides scan __________
[ ] Other __________

[NOTE: **Laboratory test results are to be used for information ONLY and may not be acceptable as legal evidence or documentation. All tests are of a destructive nature, therefore, no samples can be returned or retained for further use.**

____
Client Signature

Case Referred to __________
Samples Shipped to __________
Authorizing Signature __________ CHD __________

DH 4073, 1198