Appendix H: Record of Complaint and Investigation

1) **Online Reporting System: Kentucky Food Safety Reporting System
   (**redcap.chfs.ky.gov/surveys/?s=FAW4DLJJKK**)**

2) **KY Food Complaint System | REDCap**

3) **Record of Complaint and Investigation Form
   (DFS – 216)**

4) **Example of Record of Complaint and Investigation Form (DFS-216).**

DFS-216(9-2013)

CABINET FOR HEALTH AND HUMAN SERVICES
KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
Frankfort, KY 40621-0001
RECORD OF COMPLAINT AND INVESTIGATION

Est./Permit No.	Health Authority	Sanitarian Code	Action Code	County

FORM OF COMPLAINT	☐ Telephone ☐ Visit ☐ Email ☐ Other ☐ Letter	Date of Complaint (Month/Day/Year): _____ / _____ / _____

SOURCE OF COMPLAINT	☐ Consumer ☐ Trade/Industry ☐ Other: _____

COMPLAINT IDENTIFICATION	Name and Address (Including ZIP Code):	Home Telephone Number:
	Email:	Cell Telephone Number:
		Work Telephone Number:

DESCRIPTION OF COMPLAINT OR INJURY:

Location the Illness/ Injury occurred (home, work, restaurant, etc.):

Brand/Product Name	Product Description & labeling (attach pictures whenever possible)

Name & Address of Store Where Purchased	Shoppers Card Used ☐ No ☐ Yes	a) Shopper's Card Number:

Container - Net WT & Type	☐ Import Yes ☐ Import No Country of Origin	Date Product Was Purchased

Package Code:	Product Used (If Yes, Enter Date; How & Where) ☐ Yes ☐ No	Amount Remaining: Can Samples Be Collected ☐ Y ☐ N
UPC Code:		

MANUFACTURER / DISTRIBUTOR OF PRODUCT	Name and Address (including ZIP Code):

Image Source: https://www.chfs.ky.gov/agencies/dph/dphps/fsb/Pages/default.aspx Form DFS-216

INJURY OR ILLNESS RESULTED	a) Type Symptoms/Injury-check appropriate symptoms and list onset date and time (if available)	b) Medical Attention Sought	c) Hospitalization Required
☐ NO ☐ YES [If YES, Complete items (a) through (c)] Product Photos Attached? ☐ NO ☐ YES *(Please collect photos when possible)*	☐ Nausea Onset date/time:_____ ☐ Fever (__°F) Onset date/time:_____ ☐ Vomiting Onset date/time:_____ ☐ Paralysis Onset date/time:_____ ☐ Diarrhea Onset date/time:_____ ☐ Prostration Onset date/time_____ ☐ Headache Onset date/time_____ ☐ Other (explain)_____ Onset date/time: _____	☐ No ☐ Yes (If yes, give date, name, address, phone#) Date ___/___/____ Name _____ Address_____ _____ _____ Phone #_____ Diagnosis:_____ _____ _____	☐ No ☐ Yes (If yes, give admission date, discharge date, and facility name/address/phone #) Admission Date ___/___/___ Discharge Date ___/___/___ Facility Name_____ _____ Address_____ _____ _____ Phone #: _____ Diagnosis: _____ _____

Were Others Exposed to the Suspect Product?	A) Was Anyone Else made Ill/ Injured?	C) Were Food samples Collected?	D) Were Patient specimens collected?
☐ YES ☐ NO How Many Others Were Exposed? _____ If others were exposed to the suspect product, complete boxes A, B, C & D	☐ YES ☐ NO If yes - attach a separate page with their contact information B) How Many Were injured/ made ill?	☐ YES ☐ NO Sample Description: _____ _____ Analysis Requested:: _____ _____	☐ YES ☐ NO Sample Description: _____ _____ Diagnoses: _____ _____

List other products (food, drink, medicine) consumed during the 72 hour period before onset of illness:
_____
_____

Were Additional samples collected? ☐ Yes ☐ No Description of samples collected: _____
_____

Analysis Requested? _____ Results _____

LHD investigator (Name and Title) _____

Remainder of form to be completed by the Food Safety Branch

FSB Sample Results:_____
_____

Complaint investigation and action taken: _____
_____

Other agency responsible: ☐ Yes ☐ No;   Referred to:

Area Inspector _____	☐ FDA	☐ USDA	☐ State	☐ File	☐ Law enforcement

Remarks_____

Complaint Closed by (Name and Title)_____ Date _____

Please contact DPH at (502) 564-7181 for guidance on returning the completed DFS-216 form

Image Source: https://www.chfs.ky.gov/agencies/dph/dphps/fsb/Pages/default.aspx Form DFS-216

DFS-216(9-2013)

CABINET FOR HEALTH AND HUMAN SERVICES
KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
Frankfort, KY 40621-0001
RECORD OF COMPLAINT AND INVESTIGATION

Est./Permit No.	Health Authority	Sanitarian Code	Action Code	County

FORM OF COMPLAINT	☑ Telephone ☐ Visit ☐ Email ☐ Other ☐ Letter	Date of Complaint (Month/Day/Year): 07 / 10 / 2014
SOURCE OF COMPLAINT	☑ Consumer ☐ Trade/Industry ☐ Other:	

COMPLAINT IDENTIFICATION	Name and Address (Including ZIP Code): John Smith, 214 Any Street, Somewhere, KY 41234	Home Telephone Number: **123-456-7891**
	Email: john.smith@email.com	Cell Telephone Number: 987-654-3219
		Work Telephone Number: 456-789-1234

DESCRIPTION OF COMPLAINT OR INJURY:
mold found in Good Yogurt

Location the Illness/ Injury occurred (home, work, restaurant, etc.):
home

Brand/Product Name Good Yogurt	Product Description & labeling (attach pictures whenever possible) 8 oz container of Good Yogurt. Plastic container with blue label, white writing. Single serve portion of vanilla yogurt.

Name & Address of Store Where Purchased Neighborhood Grocery 1 Neighborly Way Hometown, KY 41235	Shoppers Card Used ☐ No ☑ Yes	a) Shopper's Card Number: 123-456-7891

Container - Net WT & Type 8 oz plastic container	☐ Import Yes ☑ Import No Country of Origin	Date Product Was Purchased 7/7/14

Package Code: 12345678910111213141516	Product Used (If Yes, Enter Date; How & Where) ☑ Yes ☐ No 7/10/14. Opened at home to consume for breakfast. Didn't notice mold until a few bites had been taken.	Amount Remaining: 7 oz Can Samples Be Collected ☑ Y ☐ N
UPC Code:		

MANUFACTURER / DISTRIBUTOR OF PRODUCT	Name and Address (including ZIP Code): Friendly Yogurt Company, 479 Outgoing Way, Personable, KY 45897

https://www.chfs.ky.gov/agencies/dph/dphps/fsb/Pages/default.aspx Example of Record of Complaint and Investigation Form

Kentucky Public Health
Prevent. Promote. Protect.

INJURY OR ILLNESS RESULTED	a) Type Symptoms/Injury-check appropriate symptoms and list onset date and time (if available)	b) Medical Attention Sought	c) Hospitalization Required

☐ NO
☑ YES
 	
[If YES, Complete items (a) through (c)]
	☑ Nausea Onset date/time:_____
	  7/10/14, 7:15 AM
	☐ Fever (__°F) Onset date/time:_____
	☑ Vomiting Onset date/time:_____
	  7/10/14, 7:30 AM
	☐ Paralysis Onset date/time:_____
		☑ No
		☐ Yes (If yes, give date, name, address, phone#)
		
		Date ___/___/___
		Name _____
			☑ No
			☐ Yes (If yes, give admission date, discharge date, and facility name/address/phone #)
			
			Admission Date ___/___/___
			Discharge Date ___/___/___
			Facility Name_____

Product Photos Attached? ☐ NO ☑ YES *(Please collect photos when possible)*	☐ Diarrhea Onset date/time:_____ ☐ Prostration Onset date/time_____ ☐ Headache Onset date/time_____ ☐ Other (explain)_____ Onset date/time: _____	Address_____ _____ _____ Phone #_____ Diagnosis:_____ _____	Address_____ _____ _____ Phone #: _____ Diagnosis: _____ _____

Were Others Exposed to the Suspect Product?	A) Was Anyone Else made Ill/ Injured?	C) Were Food samples Collected?	D) Were Patient specimens collected?
☐ YES ☑ NO How Many Others Were Exposed? _____ If others were exposed to the suspect product, complete boxes A, B, C & D	☐ YES ☑ NO If yes - attach a separate page with their contact information B) How Many Were injured/ made ill?	☐ YES ☑ NO Sample Description: _____ _____ Analysis Requested:: _____ _____	☐ YES ☑ NO Sample Description: _____ _____ Diagnoses: _____ _____

List other products (food, drink, medicine) consumed during the 72 hour period before onset of illness:

Hamburger and Fries, fish sandwich, captain crunch/milk, steak, baked potato, salad, chicken salad sandwich, bagel with cream cheese
_____

Were Additional samples collected? ☑ Yes ☐ No Description of samples collected: _____

Remaining yogurt in original container collected from home
_____

Analysis Requested? Yes _____ Results _____

LHD investigator (Name and Title) Sal Monella, Health Environmentalist _____

Remainder of form to be completed by the Food Safety Branch

FSB Sample Results:_____
_____

Complaint investigation and action taken: _____
_____

Other agency responsible: ☐ Yes ☐ No;   Referred to: _____

Area Inspector _____	☐ FDA	☐ USDA	☐ State	☐ File	☐ Law enforcement

Remarks_____

Complaint Closed by (Name and Title)_____   Date _____

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