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):	

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

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

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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