

When to use this form

Use this form if you have recently experienced symptoms such as stomach pain, nausea, vomiting or diarrhoea after consuming food at a food business located within the Waratah Wynyard municipal area. To assist us with investigating this matter we need you to provide as much information as possible including symptoms that you have experienced.

For concerns relating to any unacceptable practices you have observed or experienced in any food business please complete the Food business investigation request.

For further information on Food Safety please visit our website (www.warwyn.tas.gov.au).

Details of suspected premises

What is the name of the business? Required	
Unit/Street number	
Street Name	
Suburb	

Symptoms

What did you eat that you think made you sick? (if known) Required
When did you eat the food? Required
Date:
Approximately what time on this date? Required
What else did you eat on this date? Required

When did you become ill? Required
Approximately what time on this date? Required

What symptoms did you suffer? (Select 1 or more options) Required			
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Diarrhoea
<input type="checkbox"/>	Abdominal cramps	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Blood in stools
<input type="checkbox"/>	Other - Please provide details		

How long did the symptoms last? (Select 1 or more options) Required			
<input type="checkbox"/>	12-24 hours	<input type="checkbox"/>	24-48 hours
<input type="checkbox"/>	2-5 days	<input type="checkbox"/>	5 days

Are you still sick? (Select 1 option) Required	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Did you see a doctor? (Select 1 option) Required	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Answer this question if you selected 'yes' in *Symptoms* . *Did you see a doctor?*

Please provide the doctors details (name and address) **Required**

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Was a stool sample taken? Required	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Have you received the results of these tests? Required	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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What were the results of the tests? Required

Did anyone else eat the suspect meal Required	Yes		No	
Please detail below: Required				

What other food did you consume in the 48 hours before getting sick? Required

Additional Information

Personal details

First name Required	
Last name Required	
Email address	
Telephone number Required	
Address Required	
Age Required	
Preferred contact method (Select 1 option) Required	
Email	
Telephone	
Australia Post	
No response necessary	

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