

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	<input type="checkbox"/> Telephone <input type="checkbox"/> Visit <input type="checkbox"/> Email <input type="checkbox"/> Other <input type="checkbox"/> Letter	Date of Complaint (Month/Day/Year): ____/____/____
SOURCE OF COMPLAINT	<input type="checkbox"/> Consumer <input type="checkbox"/> Trade/Industry <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes	a) Shopper's Card Number:
Container - Net WT & Type		<input type="checkbox"/> Import Yes <input type="checkbox"/> Import No Country of Origin
Package Code:	Product Used (If Yes, Enter Date; How & Where) <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Remaining: Can Samples Be Collected
UPC Code:		<input type="checkbox"/> Y <input type="checkbox"/> N
MANUFACTURER / DISTRIBUTOR OF PRODUCT	Name and Address (including ZIP Code):	

INJURY OR ILLNESS RESULTED <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, give date, name, address, phone#) Date ___/___/___ Name _____ Address _____ _____ Phone # _____ Diagnosis: _____ _____ _____	c) Hospitalization Required <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Please collect photos when possible)</i>			
Were Others Exposed to the Suspect Product? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes - attach a separate page with their contact information B) How Many Were injured/ made ill?	C) Were Food samples Collected? <input type="checkbox"/> YES <input type="checkbox"/> NO Sample Description: _____ _____ Analysis Requested:: _____ _____	D) Were Patient specimens collected? <input type="checkbox"/> YES <input type="checkbox"/> 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 _____	<input type="checkbox"/> FDA	<input type="checkbox"/> USDA	<input type="checkbox"/> State	<input type="checkbox"/> File	<input type="checkbox"/> Law enforcement
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Remarks _____

Complaint Closed by (Name and Title) _____ Date _____

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