Appendix H: Record of Complaint and Investigation

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

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

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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 ☐ Email ☐ Letter ☐ Visit ☐ Other	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:

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

Example of Record of Complaint and Investigation Form

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
UPC Code:		Can Samples Be Collected ☑ Y ☐ N
MANUFACTURER / DISTRIBUTOR OF PRODUCT	Name and Address (including ZIP Code): Friendly Yogurt Company, 479 Outgoing Way, Personable, KY 45897	

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: ☐ 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:
Product Photos Attached? ☐ NO ☑ YES *(Please collect photos when possible)*			

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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