



Arkansas Department of Health

# Arkansas Department of Health

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**Governor Mike Beebe**

**Paul K. Halverson, DrPH, FACHE, Director and State Health Officer**

If you believe you might have been exposed to a **Foodborne or Gastrointestinal Illness**, please follow these instructions for filling out the Enteric Case Report Form.

There are Ten (10) required fields that must be filled out, and those fields are outlined in red. The required fields once clicked on will turn a "yellow" color.

- 1) Fill out all required fields: Date Submitted, Name, Age, Birthday, Contact Number (home/cell) Address, City, State, Zip, and County
- 2) Enter as much additional information as can be remembered (Hint: use events/outing as possible help to foods eaten)
- 3) Print form for your records (if desired)
- 4) Click submit form button (bottom of page H)
- 5) An ADH staff member will contact you for a follow-up interview

## Format for filling in some fields:

Dates and Birthday: mm/dd/yyyy (12/12/2000)

Date of Onset: mm/dd/yyyy (12/12/2000)

Phone number: ###-###-#### (501-555-5555)

**All information provided on this Enteric Case Report Form is CONFIDENTIAL!**



During the 5 days before illness, did patient attend group meals/events? <span style="float:right">Yes <input type="checkbox"/></span> <span style="float:right">No <input type="checkbox"/></span>											
If yes, specify below											
Activity	Date	Time	Food Eaten								
Was there any contact with animals?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Cats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>	Livestock	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unk <input type="checkbox"/>
				Dogs				Other	_____		
Have you been swimming in last 7 days in a pool, lake, river or other body of water? <span style="float:right">Yes <input type="checkbox"/></span> <span style="float:right">No <input type="checkbox"/></span> <span style="float:right">Where? _____</span>											
Does the patient/parent have knowledge of similar illness among household members, visitors, neighbors, schoolmates, etc? <span style="float:right">Yes <input type="checkbox"/></span> <span style="float:right">No <input type="checkbox"/></span> <span style="float:right">Unk <input type="checkbox"/></span> <span style="float:right">If yes, specify below.</span>											
Name	Telephone	Age	Relationship to Patient	Date of Onset							
Are there any household contacts working in food service, child care or patient care? <span style="float:right">Yes <input type="checkbox"/></span> <span style="float:right">No <input type="checkbox"/></span>											
If yes, list name of contact and place of employment below.											
Name		Place of Employment			Comments						
Date	Investigation Log					Signature					
Completed By ADH Staff only:				Title		Date					