Teller County Public Health and Environment
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This Form must be downloaded to your Device and filled out in Acrobat Reader.
DO NOT FILL THIS OUT AND SUBMIT ONLINE!!

Retail Food Establishment Consumer Complaint

This form is intended to capture information from consumers about their observations of food safety interventions and good retail practices while dining or working in retail food establishments located in Teller County. The information collected with this form can be used to help determine whether a consumer complaint should be investigated as potentially linked to the spread of foodborne illness.

Date of Complaint: _____

Name: _____ ☐ I wish to remain anonymous
Date of Birth: _____/_____/_____
Phone: _____
Email: _____

WHEN WAS THE INSTANCE AT THE RETAIL FOOD ESTABLISHMENT OBSERVED?

☐ While dining at the retail food establishment

☐ While working at the retail food establishment

Name of Retail Food Establishment: _____

Address of Retail Food Establishment: _____

Date and time of occurrence: _____

Please describe what you observed:

DID YOU GET SICK AFTER EATING AT RETAIL FOOD ESTABLISHMENT?

☐ YES ☐ NO
IF YOU ANSWERED YES, PLEASE CONTINUE TO PAGE 2.

ILLNESS DATA

Illness Onset: Date: _____ Time: _____ AM/PM **Illness Stopped**: Date: _____ Time: _____ AM/PM

☐ **Illness Ongoing**

Signs and Symptoms :

☐Diarrhea ___ Watery ___ Bloody
☐Vomiting
☐Nausea
☐Abdominal Pain
☐Fever _____°F
☐Chills
☐Headache
☐Muscle Pain
☐Dizziness
☐Double Vision
☐Jaundice
☐Weakness
☐Itching (location) _____
☐Numbness (location)_____
☐Tingling (location) _____
☐Swelling (location) _____
☐Rash
☐Other: _____

Diarrhea Onset: Date: _____ Time: _____ AM/PM **Diarrhea Stopped:** Date: _____ Time: _____ AM/PM

☐**Illness Ongoing**

Vomiting Onset: Date: _____ Time: _____ AM/PM **Vomiting Stopped:** Date:_____ Time: _____ AM/PM

☐**Illness Ongoing**

MEDICAL SERVICES

Was a doctor or other healthcare provider visited? ☐**Y** ☐**N**

Date Visited: _____ Time: _____ AM/PM Admitted: ☐**Y** ☐**N** Length of Stay: _____ (hrs)

Healthcare Facility: _____ Physician Name: _____ Phone: _____

Were Clinical Specimens Taken? ☐**Y** ☐**N** ☐Blood ☐Stool Diagnosis: _____

Would You be Willing to Provide a Stool Sample? ☐**Y** ☐**N** ☐**N/A** – Samples No Longer Available

FOOD CONSUMED

Date: _____ Location: _____ Food Eaten: _____

Time: _____ AM/PM _____ _____

_____ _____

_____ _____

Number of People in Party: _____ Number of People Reportedly Ill: _____ Group Contact: _____

(Use Following Page for Additional Comments) Phone: _____

List Anything Unusual About the Meal (Temperature, Taste, Color, Etc.)?

Submit