





# BC Yersiniosis Follow-up Form

## Groceries Consumed During the Incubation Period (including grocery stores, specialty/ethnic stores and markets) :

Store Name	Location	Details (e.g. items purchased, date of visit)

## Specific High Risk Foods/Activities

Risk factor	Eaten	Details	Risk factor	Eaten	Details
Pork	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Ham	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Unpasteurized milk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Bacon	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Milk (brand; % fat)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Pork rinds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Tofu/ Soybean	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Processed meats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Raw, local direct-from-farm produce	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Contact with hospital/LTCF	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Drinking untreated water		

## Contacts

# people in household:

Name	Date ill?	Nature of contact*	Occupation/Details	Contact phone	^Excluded?

\*Household, sexual, close contacts.

^ Please complete Contact Exclusion Form for each contact excluded.

## Occupation and Exclusion

Occupation: \_\_\_\_\_ Facility name: \_\_\_\_\_

Sensitive Setting (check if applicable):

Work/volunteer or attend day care

Work/volunteer in a health care setting

Work/volunteer as a food handler

Other (e.g. pool): \_\_\_\_\_

Excluded  Y  N Effective date (e.g. 15/Dec/07): \_\_\_\_\_

Details: \_\_\_\_\_

Symptom end date (e.g. 15/Dec/07): \_\_\_\_\_

Exclusion lifted: (e.g. 15/Dec/07): \_\_\_\_\_ MHO: \_\_\_\_\_

## Interventions

	Details
<input type="checkbox"/> Referred for Inspection	
<input type="checkbox"/> Referred to another HA	
<input type="checkbox"/> Hygiene Education Provided	
<input type="checkbox"/> Health File Sent	
<input type="checkbox"/> Other	

## Notes

Date	Comment	Initials