



# Listeria Case Questionnaire

Sporadic case

Case part of outbreak - Outbreak ref \_\_\_\_\_

Attempt	Date	Time	Outcome
1	___ / ___ / _____	_____ am / pm	_____
2	___ / ___ / _____	_____ am / pm	_____
3	___ / ___ / _____	_____ am / pm	_____
4	___ / ___ / _____	_____ am / pm	_____

**Call Outcomes**  
 OC1 – No Answer  
 OC2 – Subject not home, call back  
 OC3 – Appointment to call back  
 OC4 – Refusal  
 OC5 - Interviewed

Interviewer: \_\_\_\_\_  
 Date of interview: \_\_\_/\_\_\_/\_\_\_  
 State ID no.: \_\_\_\_\_  
 National ID no.: \_\_\_\_\_

**LOCAL PRIVACY MESSAGE**

The information you provide in this questionnaire is for the purpose of attempting to determine the cause of your illness and to prevent further cases of illness within the community. The data you provide is kept confidential and identifying information will not be disclosed for any other purpose without your consent.

If you would like further information about your illness, Queensland Health can provide a fact sheet on listeriosis.

**Note: The following preliminary information can be recorded prior to interview if known**

Person interviewed (if not case): \_\_\_\_\_

## Patient details

First Name: \_\_\_\_\_ Address: \_\_\_\_\_

Last Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_

\_\_\_\_\_ (Mobile) Post Code: \_\_\_\_\_

\_\_\_\_\_ (Work) Occupation: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female

Do you identify yourself as indigenous or of a particular ethnic background?  Yes  No

If yes:

Aboriginal  TSI  both Aboriginal & TSI  other: \_\_\_\_\_

Country of birth: \_\_\_\_\_ Language spoken at home: \_\_\_\_\_

Case admitted to hospital?  Yes  No Hospital: \_\_\_\_\_

Date of admission: \_\_\_ / \_\_\_ / \_\_\_\_\_ Date of discharge: \_\_\_ / \_\_\_ / \_\_\_\_\_

Hospital UR#: \_\_\_\_\_ Notification Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Reason for admission:  Listeriosis  Other \_\_\_\_\_

Treating Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital / Medical Practice: \_\_\_\_\_

# Medical & diagnostic information

Typing	Result	Conducted by (lab name):
Serotype (PCR)		
Binary type		
Has the isolate been forwarded for further typing? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PFGE		
Other: _____		
_____		

**Non-perinatal case**

Culture site (case):  CSF  Blood  Other \_\_\_\_\_ Collection date: \_\_\_ / \_\_\_ / \_\_\_ Day: \_\_\_\_\_

Nature of illness (case):  Meningitis  Septicaemia  Other \_\_\_\_\_

Outcome:  Survived  
 Died date of death: \_\_\_ / \_\_\_ / \_\_\_ death due to listeriosis?  Yes  No  
 Unknown

**Perinatal case**

Mother		Foetus / Neonate	
Culture Site	Specimen collection date	Culture Site	Specimen collection date
<input type="checkbox"/> Blood	___ / ___ / ___	<input type="checkbox"/> Blood	___ / ___ / ___
<input type="checkbox"/> CSF	___ / ___ / ___	<input type="checkbox"/> CSF	___ / ___ / ___
<input type="checkbox"/> Stool	___ / ___ / ___	<input type="checkbox"/> Gastric aspirate	___ / ___ / ___
<input type="checkbox"/> Placenta	___ / ___ / ___	<input type="checkbox"/> Meconium	___ / ___ / ___
<input type="checkbox"/> Other	___ / ___ / ___	<input type="checkbox"/> Other	___ / ___ / ___

Specify: \_\_\_\_\_

Specify: \_\_\_\_\_

**Outcome of pregnancy**

Still pregnant.....

Foetal death (miscarriage / stillbirth).....

Induced abortion.....

Delivery (live birth).....

Other \_\_\_\_\_

**Weeks Gestation** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Type(s) of illness in mother (tick all that apply)**

Bacteremia / sepsis

Meningitis

Febrile gastroenteritis

Amnionitis

Non-specific "flu-like" illness

None

Other: \_\_\_\_\_

Unknown

**Type(s) of illness in foetus / neonate (tick all that apply)**

Bacteremia / sepsis

Meningitis

Pneumonia

Granulomatosis infantisepticum

None

Other: \_\_\_\_\_

Unknown

**Mother's outcome**

Survived

Died

date: \_\_\_ / \_\_\_ / \_\_\_

due to Listeria

due to other cause (specify) \_\_\_\_\_

Unknown

**Foetus / Neonate outcome**

Survived

Died

date: \_\_\_ / \_\_\_ / \_\_\_

due to Listeria

due to other cause (specify) \_\_\_\_\_

Unknown

**NOTE: For perinatal cases ask the remaining questions of the mother**

# Clinical history

Date of onset of illness: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

In the 4 week period prior to diagnosis of Listeria, did you experience any of the following symptoms?

Symptom	Case (response)			Onset date
	Yes	No	DK/NS	
Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Chills/shakes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Stiff neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Confusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Diarrhoea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Vomiting .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Muscle & Body Aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____
Other symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ / ____ / ____

Specify: \_\_\_\_\_

Do you have any of the following illnesses or conditions?

Illness / condition	Case (response)			Doctor (response)		
	Yes	No	DK/NS	Yes	No	DK/NS
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal / kidney disease requiring dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other renal disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatological condition .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (_____)..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung disease (excluding asthma) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other illness or condition .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify: \_\_\_\_\_

In the 4 weeks prior to illness, were you taking any of the following treatments?

Treatments	Case (response)			Doctor (response)		
	Yes	No	DK/NS	Yes	No	DK/NS
Corticosteroids (e.g. prednisone) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclosporine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other drugs that affect the immune system .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics (_____)..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidiarrhoeal medication (e.g. Lomotil, Imodium)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antacids (e.g. Mylanta, Mucaine).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications that reduce stomach acid (e.g. Zantac, Tagamet, Somac, Losec).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (_____)..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

## Hospital admission and day visits (for treatment/care)

Did you have any hospital day visits in the 12 weeks prior to illness?  Yes  No

Date of hospital visit	Hospital	Hospital food consumed	Detail of food consumed
___ / ___ / ___	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
___ / ___ / ___	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
___ / ___ / ___	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Reason for visit (e.g. dialysis, outpatient appointment):

\_\_\_\_\_

Were you admitted to hospital in the 12 weeks prior to illness?  Yes  No

Admission	Discharge	Hospital	Reason for admission	Ward / section
___ / ___ / ___	___ / ___ / ___	_____	_____	_____
___ / ___ / ___	___ / ___ / ___	_____	_____	_____
___ / ___ / ___	___ / ___ / ___	_____	_____	_____

Foods consumed during hospital admission: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

High risk hospital foods consumed?  Yes  No  Maybe  don't know/not answered

## Environmental risk factors

<b>In the 12 weeks prior to illness, did you travel overseas, to another state or territory or anywhere within the state?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Travel type:	<input type="checkbox"/> International <input type="checkbox"/> Domestic <input type="checkbox"/> Local (please tick)
Specify location(s):	_____
	_____
Name of resort, hotel, etc:	_____
Departure date: ___ / ___ / ___	Airline/coach company: _____ Flight No. _____
Return date: ___ / ___ / ___	Airline/coach company: _____ Flight No. _____

Foods consumed on plane or bus: \_\_\_\_\_

\_\_\_\_\_

# Potential Food Sources

In the 4 weeks prior to illness ( \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_ ) did you consume any of the following?

Fruits	Yes	No	DK/NS	Type / brand / details	Where purchased / eaten
Fruit salad (self serve salad bar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fruit salad (delicatessen) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fruit salad (other source) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rockmelon / cantaloupe .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Watermelon .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Strawberries .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other berries .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other fruit Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fresh fruit juice (state type) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Vegetables / salads	Yes	No	DK/NS	Type / brand / details	Where purchased / eaten
Bagged lettuce and/or green salad mix .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bagged coleslaw mix .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Uncooked mushrooms .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alfalfa / pea sprouts .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bean sprouts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fresh herbs eaten raw .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Organic produce .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Home grown produce .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Raw vegetable juice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other raw vegetables .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specify: .....					
.....					

Dairy	Yes	No	DK/NS	Type / brand / details	Where purchased / eaten
Brie cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Camembert cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blue-veined cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fetta cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ricotta cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mozarella cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cottage cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other soft cheese (specify) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Raw / unpasteurised cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sour cream.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ice-cream .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Gelato .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Yogurt .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Raw / unpasteurised milk (cow / goat).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Flavoured milk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other dairy products: Specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
.....					

Deli	Yes	No	DK/NS	Pre-packaged	Loose (deli)	Type./ brand / details	Where purchased / eaten
Barbequed chicken .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cold cooked chicken .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Luncheon / sandwich meat .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ham .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Salami .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chicken / turkey slices.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other uncooked meat products ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pate .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Liverwurst .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Frankfurts / cheerios .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Silverside.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pre-prepared potato salad (deli)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pre-prepared coleslaw (deli) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pre-prepared pasta salad (deli)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other pre-prepared salad mix: Specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
.....							

Cold/uncooked seafood	Yes	No	DK/NS	Type / brand / details	Where purchased / eaten
Mussels .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Crab .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prawns (purchased cooked) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prawns (purchased raw) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Oysters .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Smoked salmon .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other smoked fish / seafood .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sushi / sashimi .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other seafood: Specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
.....					

Sandwiches / burgers / rolls / wraps containing:	Yes	No	DK/NS	Pre-packaged	Custom made	Type / brand / details	Where purchased / eaten
Ham .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Beef .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bacon, lettuce, tomato (BLT).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chicken .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Turkey .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other meat: Specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cheese: Specify: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other filling: Specify:.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

In the 4 weeks prior to illness, did you attend any of the following?

	Yes	No	DKNS	Date	Food
Restaurants (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1.				___/___/___	
2.				___/___/___	
3.				___/___/___	
Takeaway (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1.				___/___/___	
2.				___/___/___	
3.				___/___/___	

Any left-over high risk foods available for testing?  Yes  No

Specify: \_\_\_\_\_

### Comments and actions

Before this illness with *Listeria*, did a healthcare worker tell you to avoid certain foods to prevent listeriosis?

Yes  No

Information on *Listeria* requested?  No  Yes, date sent: \_\_\_/\_\_\_/\_\_\_

Premises/facility inspection required?  Yes  No

If yes:

Premises to be inspected by: \_\_\_\_\_

Will food samples be taken for analysis?  Yes  No

If yes, samples will be collected by (name of organisation or local council) \_\_\_\_\_

Please provide additional comments in the space provided if required:
