



Hypothesis Generating Questionnaire for **Salmonella Enteritidis** only

(Mar21)

Case Initials:	
State ID:	
<input type="checkbox"/> sporadic case <input type="checkbox"/> outbreak case	
Outbreak ref:	

Incubation	Duration	Prognosis	Shedding	Reservoir
6-72 hours (av. 12-36 hours) Longer possible, especially with low dose exposure	Diarrhoea, 1-20 days (5 days av.)	Most people completely recover within 1-2 weeks A small number develop complications such as reactive arthritis.	50% of adults >5 weeks 10% for >9 weeks Prolonged shedding more common in children	Colonised intestinal tract of many animals, including chickens, ducks, pigs, cows, reptiles, amphibians, native animals, dogs and cats

CASE DETAILS			Interviewer Initials:														
First Name:	Last Name:	Parent's Name (if applicable):															
DOB: ___ / ___ / ___	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F															
Address:																	
Home Phone:		Mobile Phone:															
Email:																	
Physician name:		Physician Phone:															
Born in Australia <input type="checkbox"/> Y <input type="checkbox"/> N <i>If no, specify where:</i>																	
Are [you/the case] of Aboriginal or Torres Strait Islander origin? (check all that apply) <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Not stated																	
			<table border="1"> <thead> <tr> <th>Date/time</th> <th>Interviewed</th> </tr> </thead> <tbody> <tr><td>1</td><td><input type="checkbox"/></td></tr> <tr><td>2</td><td><input type="checkbox"/></td></tr> <tr><td>3</td><td><input type="checkbox"/></td></tr> <tr><td>4</td><td><input type="checkbox"/></td></tr> <tr><td>5</td><td><input type="checkbox"/></td></tr> <tr><td>6</td><td><input type="checkbox"/></td></tr> </tbody> </table> <p><i>Person interviewed (if not case):</i></p> <p><i>Call back notes:</i></p> <p style="text-align: right;"><i>Interpreter used</i> <input type="checkbox"/> <i>Case lost to follow up</i> <input type="checkbox"/></p>	Date/time	Interviewed	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>
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4	<input type="checkbox"/>																
5	<input type="checkbox"/>																
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OCCUPATION (Include part-time/casual/volunteer work) and/or INSTITUTION CONTACT
What is [your/the case's] occupation? Specify
Name of work place:
Address of workplace:
Contact details for work place:
Does the case's occupation involve:
Handling food/drink? <input type="checkbox"/> Y <input type="checkbox"/> N
Working in close proximity to chickens or other avian species (egg farm or packing facility, poultry abattoir or pet store)? <input type="checkbox"/> Y <input type="checkbox"/> N
If 'Yes', please provide further details
Close contact with sick people? (e.g. health care worker) <input type="checkbox"/> Y <input type="checkbox"/> N
Close contact with the children/elderly? (e.g. child care worker?) <input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, please provided relevant public health advise for exclusion period to the case</i>
Do [you/the case] attend childcare / preschool / school /prison/ aged care facility? <input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, provide details</i>
Name :
Address :
Contact details :
<i>Please provided relevant public health advise for exclusion period to the case</i>

LABORATORY

Serotype:	Sub-type:	Specimen collection date: ____/____/____	Specimen type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other
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CLINICAL

I'm now going to ask you about some symptoms that are associated with your illness.

Did you experience any diarrhoea : Y N DK (3 or more loose stools in a 24 hour period)

Diarrhoea onset date: _____ Onset time: am pm Duration : hrs / days ongoing diarrhoea
____/____/____

Blood in stool? Y N DK

Did [you/case] experience any of these following symptoms associated with the illness?

Fever: Y N DK *If case reported fever:* Temperature recorded _____ °C DK / temp not taken

Abd Pain: Y N DK Nausea: Y N DK Vomiting: Y N DK Headache: Y N DK

Lethargy: Y N DK J/M pain: Y N DK Other: Y N DK *if yes specify:*

What was the first symptom [you/case] experienced?

First symptom: _____ First symptom onset date: ____/____/____ Onset time: am pm

Duration of illness hrs / days still ill

Emerg. Dept visit for illness? <input type="checkbox"/> Y <input type="checkbox"/> N	Date of visit(s): ____/____/____	Hospital Name:
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Admitted for illness? <input type="checkbox"/> Y <input type="checkbox"/> N	Date Admitted ____/____/____	Date Discharged: ____/____/____
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Treated for illness? <input type="checkbox"/> Y <input type="checkbox"/> N	<i>If yes:</i> <input type="checkbox"/> Rehydration <input type="checkbox"/> Antibiotics <input type="checkbox"/> other, <i>please describe:</i>
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Case deceased? <input type="checkbox"/> Y <input type="checkbox"/> N	<i>If yes:</i> Date of death:
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Underlying conditions or medications that suppress the immune system (e.g. pregnancy, diabetes, cancers, steroids, etc.) Y N DK

If yes: specify:

EXPOSURE PERIOD

I'm going to ask some questions about what you did before [you/the case] got sick, including some questions that are specifically about the 7 days before the start of [your/the case's] illness.

The first day of illness was (day and date)

____/____/____

Seven days before this was (day and date)

____/____/____

It is often helpful to have a calendar or diary in front of you to help you remember what you did during this time.

CONTACT EXPOSURES

In the 7 days before your illness, did [you/the case] have contact with a:

- Family member with a similar illness? Y N DK *if yes complete below table*
- Friend or work/school colleague with a similar illness? Y N DK *if yes complete below table*

Name	Relationship	Illness onset	Illness description	Phone contact

TRAVEL EXPOSURES

In the 7 days prior to your illness, did [you/the case] travel?

Overseas? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	If yes, provide travel details: Destination(s): _____
Interstate? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Date departure: ____/____/____ Date of return: ____/____/____
Within State? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Mode of travel: <input type="checkbox"/> air <input type="checkbox"/> car <input type="checkbox"/> train <input type="checkbox"/> bus <input type="checkbox"/> other, specify: Name of airline / tour company / travel numbers (if applicable): _____

Case classification for international travel

Travel acquired salmonellosis (international travel for *entire* incubation) STOP interview

Possibly travel acquired salmonellosis (international travel for *part* of incubation) CONTINUE interview

Locally acquired salmonellosis (*no* international travel during incubation) CONTINUE interview

ENVIRONMENTAL EXPOSURES

In the 7 days prior to [your/the case's] illness, did [you/the case] *Name/location/description/details of exposure:*

Live on or visit a rural property	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Have any contact with farm or zoo animals (petting zoos, farms, shows, etc)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Have contact with of any the following pets		
Dogs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Cats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Pet fish	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Lizards, snakes, turtles, other reptiles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Backyard chickens/hens	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other pets, specify:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	

If 'yes' to backyard chickens:

When were they purchased? (e.g. date) _____

Where were they purchased (address/business name)? _____

What is the age of the new chickens? (e.g. day old chicks) _____

If yes to any Pets, were they fed:		
Dry food, tinned food, raw meat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Fish pellets, flakes, worms	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Mice, crickets, other reptile/snake food	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Hay, pellets, seed, other animal food/treats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Other pet food, specify:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Have any contact with native animals	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Have any exposure to chicken manure?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
If yes to manure, please record other details (e.g. address where case exposed, how exposure occurred, brand of manure, place of purchase)		
Swim in / paddle in any pools, dams, or other water ways?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Participate in any sports that include direct contact with water or mud?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Drink any untreated water?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Drink any bottled water?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	

HOME FOOD PURCHASES

Where did you purchase the groceries consumed in the 7 days prior [your/the case's] illness?

Store	Where (location)	Chicken	Eggs
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<input type="checkbox"/> Aldi		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coles		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IGA		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Woolworths		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Butchery		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Local Markets		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fruit & Veg shop		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Home Grown or Self-Slaughtered		<input type="checkbox"/>	<input type="checkbox"/>
Do you have customer/loyalty cards for any supermarkets where you shopped?	<input type="checkbox"/> Y <input type="checkbox"/> N		
May we obtain your consent to contact supermarkets with your loyalty card information to request information on recent purchases as part of our investigation?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Woolworths rewards card number (Hint: Begins with '9', underneath barcode):			
Coles flybuys number (Hint: Begins with '2', underneath barcode):			
Any other member or rewards card number (e.g. Costco member):			

FOOD EATEN OR PREPARED OUTSIDE THE HOME			
In the 7 days prior to [your/the case's] illness, did [you/the case] eat food from:			
Food Premise Type	Where: (Name and location of premises)	When: (date and time)	What: (did you eat)
Cafes, restaurants, bars	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		
Bakeries	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		
Takeaways, including from service stations, fast food outlets, etc.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		
Continental deli or specialty grocer (e.g. Asian supermarkets)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		
Farmers Markets or other market stalls	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		

Direct from farms	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			
Home delivered food e.g. Lite & Easy, Meals On Wheels	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			
Social gatherings, such as: festivals - weddings - parties - religious events - work conferences?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			

SPECIAL DIETS		
Are [you/the case] on a special diet?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Details:
Are [you/the case] allergic to any foods?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Details:
Are there any foods or food groups that [you/ the case] <i>never</i> eat?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Details:

PRIORITY TRAWLER:				
In the 7 days prior to [your/the case's] illness, did [you/the case] eat any EGGS or EGG CONTAINING foods eaten out or at home?				
EGGS or EGG CONTAINING foods	Eaten during:		Type / brand / description	Where purchased or eaten (NB: If no specific location recalled, try to obtain approximate location details OR case's regular place of purchase)
	7 day period before illness? →	3 day period before illness?		
Eggs eaten at home (Including egg in salads, on burgers, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Free range <input type="checkbox"/> Barn Laid <input type="checkbox"/> Caged <input type="checkbox"/> Organic <input type="checkbox"/> Backyard <input type="checkbox"/> DK <input type="checkbox"/> Runny <input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> DK <i>Brand:</i> <i>Other details: (e.g. stamp or best before date) Eggs/egg carton still in the fridge/at home?</i>	

Eggs eaten away from home (Including egg in salads, on burgers, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Boiled <input type="checkbox"/> Poached <input type="checkbox"/> Fried <input type="checkbox"/> Scrambled <input type="checkbox"/> Other Specify: <input type="checkbox"/> Runny <input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> DK <i>Other details:</i>	
EGGS or EGG CONTAINING foods	Eaten during:		Type / brand / description	Where purchased or eaten
	7 day period before illness? →	3 day period before illness?		
Tiramisu	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Uncooked cake batter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Homemade custard	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Chocolate mousse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Homemade or deep fried ice-cream	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Raw egg milkshake/egg nog	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Homemade Caesar salad dressing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	

Homemade mayonnaise/aioli	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Homemade tartare sauce	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Homemade Hollandaise/ béarnaise sauce	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw eggs used? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK <i>Other details:</i>	
Asian roll, including pork rolls, etc	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Details:</i>	
Any other food or drink containing raw eggs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Details:</i>	

PRIORITY TRAWLER:

In the 7 days prior to [your/the case's] illness, did [you/the case] eat any of the following POULTRY products PURCHASED RAW and prepared/cooked at home?				
RAW POULTRY	Eaten during:		Type / brand / description	Where purchased
	7 day period before illness?	3 day period before illness?		
Whole chicken	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> <i>Free Range</i> <input type="checkbox"/> <i>Organic</i> <input type="checkbox"/> <i>Corn Fed</i> <input type="checkbox"/> <i>Steamer</i> (i.e. cheaper chicken used for soups, stocks etc) <input type="checkbox"/> <i>General</i> <i>Other details:</i>	
Chicken pieces (e.g. thigh, wings)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> <i>Free Range</i> <input type="checkbox"/> <i>Organic</i> <input type="checkbox"/> <i>Corn Fed</i> <input type="checkbox"/> <i>Steamer</i> (i.e. cheaper chicken used for soups, stocks etc) <input type="checkbox"/> <i>General</i> <input type="checkbox"/> <i>Pre-packaged</i> [†] <input type="checkbox"/> <i>From deli</i> [‡] <i>Specify cuts:</i>	
Chicken skewer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> <i>Free Range</i> <input type="checkbox"/> <i>Organic</i> <input type="checkbox"/> <i>Corn Fed</i> <input type="checkbox"/> <i>General</i> <input type="checkbox"/> <i>Pre-packaged</i> [†] <input type="checkbox"/> <i>From deli</i> [‡] <i>Specify flavour:</i>	
Chicken mince	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Other details:</i>	
Chicken sausages	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Other details:</i>	
chicken purchased raw and cooked at home	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> <i>Pre-packaged</i> [†] <input type="checkbox"/> <i>From deli</i> [‡] <i>Specify what:</i>	

(e.g. schnitzel, kiev, chicken paddies)				
Turkey	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Details:</i>	
Duck	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Details:</i>	
Other raw poultry	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Pre-packaged [†] <input type="checkbox"/> From deli [‡] <i>Specify what:</i>	

[†] pre-packaged: purchased in a seal package

[‡] from deli: means served to you directly from a deli display or sliced for you at the time of purchase

PRIORITY TRAWLER:				
In the 7 days prior to [your/the case's] illness, did [you/the case] eat any of the following POULTRY products PURCHASED COOKED and eaten out or at home?				
COOKED POULTRY	Eaten during:		Type / brand / description	Where purchased or eaten
	7 day period before illness? →	3 day period before illness?		
Cooked BBQ or Charcoal chicken	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Specify type:</i>	
Shredded chicken	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Pre-packaged [†] <input type="checkbox"/> From deli [‡] <i>Other details:</i>	
Chicken burger	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Other details:</i>	
Other cooked chicken (e.g. chicken kebab, crumbed chicken pieces, chicken soup/stock, stir-fry Schnitzel)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	<i>Details:</i>	

EDUCATION: Preventing Salmonella and other foodborne diseases

Key tips
Wash your hands before handling food and often during food preparation especially when handling raw eggs and chicken.
Wash and clean all surfaces and equipment used for food preparation or serving especially when handling raw eggs and chicken.

Keep clean
 Wash your hands after going to the toilet and changing the baby. When handling and caring for animals wash hands before and after being around or handling animals, their food, or supplies.
 Protect kitchen areas and food from insects, pests and other animals.

Separate raw and cooked foods
 Separate raw meat, poultry, fish and seafood from other foods.
 Use separate equipment and utensils such as knives and cutting boards for handling raw foods.
 Store foods in covered containers to avoid contact between raw and cooked foods.

Cook thoroughly

Cook food thoroughly, especially meat, poultry, eggs, fish and seafood.

For meat and poultry, make sure juices are clear, not pink.

Bring foods like soups and stews to boiling point.

Reheat cooked food thoroughly. Bring to the boil or heat until too hot to touch. Stir while re-heating.

Keep food at safe temperatures

Do not leave cooked food at room temperature for more than two hours.

Do not store food too long, even in a refrigerator.

Do not thaw frozen food at room temperature.

Food for infants and young children and other people with low immune systems should ideally be freshly prepared and not stored at all after cooking.

Use safe water and foods

Do not use food beyond its expiry date.

Wash fruits and vegetables in clean water, especially if eaten raw.

Hygiene and preventing transmission discussed

Y N

Would you like us to send you a fact sheet with information about *Salmonella*?

Y N

CONCLUSION

Thanks for your time today.

The information you provide in this questionnaire is for the purpose of trying to prevent further cases of illness.

We do this by trying to find out what is likely to have caused your illness and also by providing you with information to reduce the spread of illness to others.

The data collected is kept confidential and identifying information will not be disclosed for any other purpose without your consent

If we have any further questions, could we contact you again?

Y N

FOLLOW-UP AND EXCLUSIONS

Exclusion required?

Y N

Exclusion discussed with case / parent / guardian

Y N

JURISDICTIONAL EXCLUSION GUIDELINES

Jurisdiction to add guidelines...

INTERVIEW COMPLETED BY

Name of Interviewer:

How well did the case recall the information requested? very well well not well not at all

GENERAL NOTES: