



Food samples must be associated with human case(s) or investigation(s) related to human infection AND submitted by a Medical Officer of Health (MOH) or designate (PHI, EHO)

Once completed send the sample and requisition to:

Calgary Site

3030 Hospital Drive NW
Calgary, AB T2N 4W4
Phone 403.944.1200 Fax 403.270.2216

Edmonton Site

Room 2B3.02 WMC University of Alberta Hospital
8440-112 Street, Edmonton, AB T6G 2J2
Phone 780.407.7121 Fax 780.407.3864

Collection Location	Sample Collection Location <i>(e.g. if from private home, write name of family; if from establishment, write name of restaurant)</i>			Sample Collection Address	
				City/Town	
				Province	Postal Code
				Phone	
Requestor(s)	Requestor Name <i>(MOH or Designate)</i>			Copy to MOH	
	Location/Facility/Address			Location/Facility/Address	
	City	Postal Code		City	Postal Code
	Phone	Fax		Phone	Fax
	EI # <i>(if applicable)</i>				
Collection	Collection Date <i>(yyyy-Mon-dd)</i>	Time <i>(24 hr)</i>	Collector ID	Storage details at time of collection <input type="checkbox"/> Refrigerated <input type="checkbox"/> Frozen <input type="checkbox"/> Room Temp	
	Sample Type/Description <i>(e.g. chicken, pizza, dog treat)</i>			Original Sample Source <i>(If from private home, write name of restaurant/facility)</i>	
	Brand Name			Expiry Date <i>(yyyy-Mon-dd)</i>	Lot Number
Clinical Diagnosis	<input type="checkbox"/> Abdominal cramps		<input type="checkbox"/> Fever		Date of Onset <i>(yyyy-Mon-dd)</i>
	<input type="checkbox"/> Chills		<input type="checkbox"/> Nausea		Number of people ill
	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Vomiting		Incubation Period
<input type="checkbox"/> Bloody Diarrhea		<input type="checkbox"/> Other _____		Suspect Agent	
Test Request(s)	<input type="checkbox"/> Aerobic Plate Count (APC)				
	<input type="checkbox"/> Food Poisoning Organisms (<i>B. cereus</i> , <i>C. perfringens</i> , <i>S. aureus</i>)				
<input type="checkbox"/> Aeromonas		<input type="checkbox"/> Campylobacter		<input type="checkbox"/> E. coli O157	
<input type="checkbox"/> Yersinia		<input type="checkbox"/> Other _____		<input type="checkbox"/> Salmonella	
				<input type="checkbox"/> Shigella	
Laboratory Use Only	Conditions upon receipt at PLNA				
	<input type="checkbox"/> Coolant/Ice pack	<input type="checkbox"/> Frozen	<input type="checkbox"/> Room Temperature	<input type="checkbox"/> Unopened/Intact	Initials _____
	Conditions upon receipt at PLSA				
	<input type="checkbox"/> Coolant/Ice pack	<input type="checkbox"/> Frozen	<input type="checkbox"/> Room Temperature	<input type="checkbox"/> Unopened/Intact	Initials _____
	Sample weight with packaging _____				
Sample weight or volume available for culture _____			Initials _____		
Comments					