St John Ambulance Australia

Gastrointestinal Illness Questionnaire

This form is to be completed for patients presenting with signs and symptoms of gastrointestinal illness in addition to a St John Extended Practice Patient Record or OB12 Patient Record.

St John

Patient Details:

Surname:		First Name:			Sex:	M ❑ F ❑
DOB:	/ /	Age:		Mobile Phone:		

Are you a (please tick):

❑ Food Handler
❑ Health Professional
❑ Child Carer
❑ Event Staff ❑ Patron

Do you have any of the following (please tick)?

❑ Diarrhoea ❑ Blood in Stool
❑ Vomiting ❑ Conjunctivitis
❑ Abdominal Pain ❑ Headache
❑ Temperature > 38.0°C ❑ Shivering, uncontrollably

When did your symptoms start?

Date:	/ /	Time:	:

Have you been exposed to other people with similar symptoms prior to the onset of your symptoms?

❑ Yes ❑ No

Where did you last eat prior to becoming ill? Please provide the name and location of any food outlet or vender (if applicable).

____

What did you eat there?

____

Which public toilets have you been using?

____

Gastrointestinal illness is highly contagious and difficult to control in a mass gathering environment. From time to time it is necessary to provide details regarding patient presentations to the Department of Health to ensure appropriate management of any outbreaks.

Do you give St John Ambulance permission to share this information with public health officials?

❑ Yes ❑ No

Do you give St John Ambulance and these bodies permission to contact you to investigate outbreaks of gastrointestinal illness?

❑ Yes ❑ No

St John Use Only

Patient Presentation

Date: ___ /___ /______

Time: ___ :___

Event Name:

____

OB12 No/MAT UR No

____

St John Treatment:

❑ IVT
❑ Transported to Hospital

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