CDC/California Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number

Fax this form to the **County of Riverside, Department of Public Health, Disease Control at (951) 358-5102.** For additional information please call (951) 358-5107.

Reporting of Case

Today's Date: __/__/__

Name of Person Completing this Form: ____________

Phone: ____________

Affiliation (e.g., clinic, health department): ____________

Fax: ____________

E-mail Address: ____________

Patient's Address at Time of Visit for Suspected LGV

Last Name: ____________ First Name: ____________ Middle Initial: ____

Home Phone: ____________

Residence Street: ____________ (Apt No.)

Work Phone: ____________

City: ____________ State: ____ Zip: ____

Health Jurisdiction/County/State/Country of Residence: ____________

Patient's Demographic Information

Gender: ☐ Male ☐ Female ☐ Transgender (☐ M-to-F ☐ F-to-M)

Date of Birth: __/__/__

Age: ____

Hispanic/Latino? ☐ Y ☐ N ☐ U

Race (check all that apply):

- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Other: ____________
- ☐ Unknown

Clinical Information

Date of Initial Health Care Visit for Suspected LGV: __/__/__

Clinic where patient was seen for suspected LGV:

Clinic Name: ____________

Street: ____________

City: ____________ State: ____ Zip: ____

Patient's Clinic ID#: ____________

Clinic Type:

- ☐ STD Clinic
- ☐ ID Clinic
- ☐ HIV/AIDS Clinic
- ☐ GI Clinic
- ☐ Primary Care
- ☐ Other: ____________
- ☐ Emergency Department

Setting:

- ☐ Kaiser
- ☐ Public Community Clinic
- ☐ Private Practice
- ☐ Correctional
- ☐ University Hospital
- ☐ Other: ____________
- ☐ Emergency Department

What was the patient's chief complaint(s) at the initial clinic visit for suspected LGV?
(Please list): ____________

Is this patient the sex partner of a person diagnosed with proven or suspected LGV? ☐ Y ☐ N ☐ U

Does the patient report having a sex partner with symptoms consistent with LGV? ☐ Y ☐ N ☐ U

Date Case Closed: __/__/__ DIS: ____ Sup: ____

Case Number ______

Symptoms

At the initial clinic visit for suspected LGV, did the patient give a history of having any of the following?

Symptom	Approximate Date of Onset	Duration (# Days)	Still Present?
[Y] [N] [U] Anal Discharge	__/__/__	____	[Y] [N]
[Y] [N] [U] Rectal Bleeding	__/__/__	____	[Y] [N]
[Y] [N] [U] Constipation	__/__/__	____	[Y] [N]
[Y] [N] [U] Lymph node enlargement in groin	__/__/__	____	[Y] [N]
[Y] [N] [U] Ulcer Painful? [Y] [N] Site: ______	__/__/__	____	[Y] [N]
[Y] [N] [U] Papule Painful? [Y] [N] Site: ______	__/__/__	____	[Y] [N]
[Y] [N] [U] Fever	__/__/__	____	[Y] [N]
[Y] [N] [U] Weight Loss	__/__/__	____	[Y] [N]
[Y] [N] [U] Anal Spams (cramping)	__/__/__	____	[Y] [N]
[Y] [N] [U] Other: ______	__/__/__	____	[Y] [N]

Physical Exam Findings

[Y] [N] [U] **Inguinal Lymphadenopathy** *(if Yes, complete below)*

- [Y] [N] [U] Unilateral
- [Y] [N] [U] Bilateral
- [Y] [N] [U] Tender at Adenopathy site
- [Y] [N] [U] Bubo
  If Yes, is it draining? [Y] [N] [U]

[Y] [N] [U] Ulcer *(if Yes, complete below)*

Tender? [Y] [N]

Site: ______

[Y] [N] [U] Papule *(if Yes, complete below)*

Tender? [Y] [N]

Site: ______

[Y] [N] [U] Mucous or purulent anal discharge

[Y] [N] [U] Rectal bleeding

[Y] [N] [U] Fever
If Yes, constitutional symptoms? [Y] [N] [U]

[Y] [N] [U] Weight Loss

[Y] [N] [U] Other *(list)*:

______

______

______

Clinical Procedures

[Y] [N] [U] Rectal exam (digital) done?
If Yes, indicate findings:

______

______

______

[Y] [N] [U] Anoscopy/Proctoscopy/Sigmoidoscopy done?
If Yes, indicate findings:

______

______

______

Chlamydia History

Does the patient have a history of chlamydia infection in the past year? [Y] [N] [U]

If Yes, Anatomic Site: ______ Date: __/__/__ Treatment: ______

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Case Number

Patient's Self-Reported HIV Status

Patient knows HIV status? [Y] [N] [U] [R]

If Yes, Status? [ ] Infected [ ] Not Infected [ ] Refused

__/____ If Infected, Date of Diagnosis (mm/yyyy)

__/____ If Not Infected, Date of Last Test (mm/yyyy)

Taken anti-retroviral therapy in the past 12 months? [Y] [N] [U] Ever? [Y] [N] [U]

Chlamydia Tests Conducted

Check which chlamydia tests were conducted at visit for suspected LGV and test results, if available:

CT Specimen Type & Lab Used	CT Test Results	Test Type (if known)
[Y] [N] [U] Urine Lab Name: ____	[ ] Positive [ ] Equivocal [ ] Negative [ ] Unk	[ ] GenProbe Aptima [ ] Roche Amplicor [ ] Unknown [ ] BD ProbeTec [ ] Other: ____
[Y] [N] [U] Urethral Swab Lab Name: ____	[ ] Positive [ ] Equivocal [ ] Negative [ ] Unk	[ ] Culture [ ] GenProbe Aptima [ ] Other: ____ [ ] GenProbe PACE [ ] BD ProbeTec [ ] Unknown [ ] Roche Amplicor [ ] Antigen detection (specify): ____
[Y] [N] [U] Rectal Swab Lab Name: ____	[ ] Positive [ ] Equivocal [ ] Negative [ ] Unk	[ ] Culture [ ] GenProbe Aptima [ ] Other: ____ [ ] GenProbe PACE [ ] BD ProbeTec [ ] Unknown [ ] Roche Amplicor [ ] Antigen detection (specify): ____
[Y] [N] [U] Serology Lab Name: ____	Titer (if known): ____ Optical Density: ____	[ ] CF [ ] MIF [ ] EIA [ ] Unknown
[Y] [N] [U] Other: ____ Lab Name: ____	Describe Results: ____	Describe Test Type: ____

Other STD Tests Conducted

Check other STD tests for which tests were conducted at the initial LGV clinic visit and test results, if available:

STD	Test Results	Test Type (if known)
[Y] [N] [U] Gonorrhea - Urine	[ ] Positive [ ] Negative [ ] Unk	[ ] NAATs [ ] Unk
[Y] [N] [U] Gonorrhea - Rectal	[ ] Positive [ ] Negative [ ] Unk	[ ] Culture [ ] NAATs [ ] Unk
[Y] [N] [U] Gonorrhea - Oropharyngeal	[ ] Positive [ ] Negative [ ] Unk	[ ] Culture [ ] NAATs [ ] Unk
[Y] [N] [U] Trichomonas	[ ] Positive [ ] Negative [ ] Unk	[ ] Culture [ ] Wet mount [ ] Unk
[Y] [N] [U] Syphilis - Non-Treponemal	[ ] Reactive - Titer: 1: ____ [ ] Non-reactive [ ] Unk	Serology: [ ] RPR [ ] VDRL [ ] Other ____ [ ] Unk
[Y] [N] [U] Syphilis - Treponemal	[ ] Reactive [ ] Non-reactive [ ] Unk	Serology: [ ] FTA [ ] TP-PA [ ] Other ____ [ ] Unk
[Y] [N] [U] Syphilis Ulcer/Chancre	[ ] Positive [ ] Negative [ ] Unk	[ ] Darkfield [ ] Unk
[Y] [N] [U] Genital/Rectal Herpes	[ ] Positive [ ] Negative [ ] Unk	[ ] Culture [ ] Other: ____ [ ] Unk
[Y] [N] [U] Other: ____	[ ]	[ ]

LGV Treatment

Was treatment given for suspected LGV? [Y] [N] [U]

If Yes, Drug: ____ Dose: ____ Frequency: ____ # Days: ____

Patient's Sexual History

Number of **male sex partners** the patient had in the past **12 months**: ______

Number of **male sex partners** the patient had in the past **3 months**: ______

In the past **3 months**:

- Did the patient have sex (anal, vaginal) without a condom with any of these male partners? [Y] [N] [U]
- Did the patient have receptive anal intercourse with any of these male partners? [Y] [N] [U]
- Did the patient have receptive anal fisting with any of these male partners? [Y] [N] [U]
- **For male patients only:** Did the patient have insertive anal intercourse with any of these male partners? [Y] [N] [U]

Number of **female sex partners** the patient had in the past **12 months**: ______

Number of **female sex partners** the patient had in the past **3 months**: ______

In the past **3 months**:

For male patients only:

- Did the patient have sex (anal, vaginal) without a condom with any of these female partners? [Y] [N] [U]
- Did the patient have insertive anal intercourse with any of these female partners? [Y] [N] [U]

Risk Factors

Which of the following drugs were used in the past **12 months**?

Drug										
Marijuana	Y	N	U	R	Other #1:	Y	N	U	R	
Crack Cocaine	Y	N	U	R	Specify: ______					
Cocaine	Y	N	U	R	Other #2:	Y	N	U	R	
Ecstasy	Y	N	U	R	Specify: ______					
Heroin	Y	N	U	R	Other #3:	Y	N	U	R	
Methamphetamine	Y	N	U	R	Specify: ______					

In the **12 months** before the suspected LGV diagnosis:

Question				
Been in Jail/Juvenile Detention Center?	Y	N	U	R
Been in Prison/Long-Term Correctional Facility?	Y	N	U	R
Been a Member of Gang? ______ Gang Name	Y	N	U	R
Gave Money/Drugs for Sex?	Y	N	U	R
Received Money/Drugs for Sex?	Y	N	U	R
Had any Sex Partners who have ever been in jail/prison/juvenile hall?	Y	N	U	R

Venues

In the **3 months** before this suspected LGV diagnosis, where did the patient meet any **NEW** or **ANONYMOUS** sex partners? [R]

☐ No new or anonymous partners in past 3 months

Venue	Meeting Venue	Name(s) of Venues	Venue	Meeting Venue	Name(s) of Venues
Bars/Clubs	Y N U R	______	Circuit Parties	Y N U R	______
Baths/Spas	Y N U R	______	Telephone Chat Lines	Y N U R	______
Sex Clubs	Y N U R	______	Other #1	Y N U R	______
Internet/Chat Rooms/Email	Y N U R	______	Other #2	Y N U R	______
Private Parties	Y N U R	______	Other #3	Y N U R	______

Patient's Travel History

Did the patient travel outside the state where the clinic is located in the past **3 months** (including international travel)? [Y] [N] [U]

Where did the patient travel (list)?

Location: ______ Dates: ______

Location: ______ Dates: ______

Location: ______ Dates: ______

Did the patient have sex there (other than someone with whom they traveled to that location)? [Y] [N] [U]