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

Case Number ____________

If you have a suspected LGV case, please complete this case report form and send to your local STD Control office and fax a copy to Denise Gilson at (916) 552-8974. For clinical questions, please call your local STD Control office or contact Dr. Chris Hall at (510) 625-6006 or chall@dhs.ca.gov.

Reporting of Case

___/___/___ Today's Date

Name of Person Completing this Form ____________

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

E-mail Address ____________

Phone ____________

Fax ____________

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
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ 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
- ☐ HIV/AIDS Clinic
- ☐ Primary Care
- ☐ Emergency Department
- ☐ ID Clinic
- ☐ GI Clinic
- ☐ Other: ____________

Setting:

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

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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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: _________

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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**:

Question	
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:

Question	
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		Other	
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

	Meeting Venue	Name(s) of Venues		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

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Additional Comments

Additional comments you may have (e.g., other history, risk factors, or behaviors of relevance for this suspected case):