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

Name of Person Completing this Form

Phone

Today's Date

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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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**:

- 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**?

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:

- 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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