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

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

Today's Date

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 ( [ ] Yes [ ] No [ ] Unknown)

Date of Birth: __/__/____

Age: ___________

Hispanic/Latino? [ ] Yes [ ] No [ ] Unknown

Race (check all that apply):

[ ] White

[ ] American Indian/Native Alaskan

[ ] 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

[ ] Other

[ ] Primary Care

[ ] Other

[ ] Emergency Department

Setting:

[ ] Kaiser

[ ] Public Health 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? [ ] Yes [ ] No [ ] Unknown

Does the patient report having a sex partner with symptoms consistent with LGV? [ ] Yes [ ] No [ ] Unknown

Date Case Closed

D I S

Sup
### Symptoms

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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Approximate Date of Onset</th>
<th>Duration (if days)</th>
<th>Still Present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anus Discharge</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Rectal Bleeding</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Lymph node enlargement in groin</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Ulcer</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Painful? Y N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papule</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Painful? Y N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Anal Spasm (cramping)</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Y N</td>
</tr>
</tbody>
</table>

### Physical Exam Findings

- Inguinal Lymphadenopathy (if Yes, complete below)
  - Unilateral
  - Bilateral
  - Tender at Adenopathy site
  - Ulcer (if Yes, complete below)
    - Tender?
    - Site:
  - Pustule (if Yes, complete below)
    - Tender?
    - Site:

- Macular or purulent anal discharge
- Rectal bleeding
- Fever
- Weight Loss
- Other (list):

### Clinical Procedures

- Rectal exam (digital) done?
  - If Yes, indicate findings:
    - 
    - 
    - 

- Analcopy/Prectoscopy/Sigmoidoscopy done?
  - If Yes, indicate findings:
    - 
    - 
    - 

### Chlamydia History

Does the patient have a history of chlamydia infection in the past year? Y A U

- If Yes, Anatomic Site:
- Date: / / 
- Treatment:
### Patient's Self-Reported HIV Status

- **Case Number:**

- **Patient Knows HIV Status?**
  - [ ] Yes
  - [ ] No
  - [ ] Unsure

- **If Yes, Status?**
  - [ ] Infected
  - [ ] Not Infected
  - [ ] Not Sure

- **If Infected, Date of Diagnosis (MM/DD/YYYY):**
- **If Not Infected, Date of Last Test (MM/DD/YYYY):**

- **Taken anti-retroviral therapy in the past 12 months?**
  - [ ] Yes
  - [ ] No
  - [ ] Unsure

- **Ever?**
  - [ ] Yes
  - [ ] No
  - [ ] Unsure

### Chlamydia Tests Conducted

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

<table>
<thead>
<tr>
<th>CT Specimen Type &amp; Lab Used</th>
<th>CT Test Results</th>
<th>Test Type (If known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urethral Swab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal Swab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Name:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Test ofapture:**
- **Ctential Density:**

- **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:

<table>
<thead>
<tr>
<th>STD</th>
<th>Test Results</th>
<th>Test Type (If known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea - Urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea - Rectal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea - Oropharyngeal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trichomonas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis - Non-Primaral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis - Primaral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Ulcer/Chancro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital/Rectal Herpes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **NAATs:**
- **Ctulture:**
- **Serology:**

### LGV Treatment

- **Was treatment given for suspected LGV?**
  - [ ] Yes
  - [ ] No
  - [ ] Unsure

- **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:
- 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
- Crack Cocaine: Y/N/U
- Cocaine: Y/N/U
- Ecstasy: Y/N/U
- Heroin: Y/N/U
- Methamphetamine: Y/N/U
- Other #1: Y/N/U
- Other #2: Y/N/U
- Other #3: Y/N/U

Specify: ____________________________

In the 12 months before the suspected LGV diagnosis:
- Been in Jail/Juvenile Detention Center? Y/N/U
- Been in Prison/Long-Term Correctional Facility? Y/N/U
- Been a Member of Gang? Y/N/U
  - Gang Name: _______________________
- Gave Money/Drugs for Sex? Y/N/U
- Received Money/Drugs for Sex? Y/N/U
- Had any Sex Partners who have ever been in jail/prison/juvenile hall? Y/N/U

**Venues**

In the 3 months before this suspected LGV diagnosis, where did the patient meet any NEW or ANONYMOUS sex partners? Y/N/U

- No new or anonymous partners in past 3 months

<table>
<thead>
<tr>
<th>Meeting Venue</th>
<th>Name(s) of Venues</th>
<th>Circuit Parties</th>
<th>Meeting Venue</th>
<th>Name(s) of Venues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bars/Clubs</td>
<td>Y/N/U</td>
<td></td>
<td>Bars/Clubs</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Bars/Spas</td>
<td>Y/N/U</td>
<td></td>
<td>Bars/Spas</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Sex Clubs</td>
<td>Y/N/U</td>
<td></td>
<td>Sex Clubs</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Internet/Chat Rooms</td>
<td>Y/N/U</td>
<td></td>
<td>Internet/Chat Rooms</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Private Parties</td>
<td>Y/N/U</td>
<td></td>
<td>Private Parties</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Telephone Chat Lines</td>
<td></td>
<td></td>
<td>Other #1</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Other #2</td>
<td></td>
<td></td>
<td>Other #2</td>
<td>Y/N/U</td>
</tr>
<tr>
<td>Other #3</td>
<td></td>
<td></td>
<td>Other #3</td>
<td>Y/N/U</td>
</tr>
</tbody>
</table>

**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 last?

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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