Lymphogranuloma Venereum (LGV) Suspected Case-Patient Information

If you have a suspected LGV case or questions about this form, please contact your state and local health departments, and Katrina Park at the Centers for Disease Control and Prevention's Division of STD Prevention at (404) 639-1807, Fax # (404) 639-8610 or KPark2@cdc.gov.

Today's Date : M M - D D - Y Y

Name of Person Completing this Form:_____

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

Phone # :_____ Fax # :_____ Email :_____

Clinic Where Patient was Seen for Suspected LGV :_____

Clinic Location : City_____ State :_____

Clinic Type: ☐ STD Clinic ☐ Primary Care
☐ HIV/AIDS/ID Clinic ☐ Emergency Department
☐ Other (Specify Type):_____

Patient's Clinic ID#:_____

Were your local and state health departments informed of this suspected case? ☐ yes ☐ no ☐ unk
If no or unknown, please contact your local and state health departments.

Patient's Demographic Information

1. Sex: ☐ Male ☐ Female ☐ Transgender (☐ M-to-F or ☐ F-to-M)

2. Age:_____ 3. State Where Patient Resides: _____ 4. Patient's Zipcode: __ __ __ __ __

5. Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

6. Race (Check all that apply): ☐ American Indian/Alaskan Native ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Black ☐ Asian
☐ Other:_____ ☐ Don't know

Clinical Information

7. Date of Initial Health Care Visit for Suspected LGV: M M - D D - Y Y

8. What was the patient's chief complaint(s) at the initial clinic visit for suspected LGV ?
_____

9. Is this patient the sex partner of a person diagnosed with proven or suspected LGV ?
☐ yes ☐ no ☐ unknown

10. Does the patient report having a sex partner with symptoms consistent with LGV?
☐ yes ☐ no ☐ unknown

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11. Symptoms: Did the patient report having any of the following symptoms?

Symptom		Duration (# Days)	Still Present?
Anal Discharge	□ yes □ no □ unk		□ yes □ no □ unk
Rectal Bleeding	□ yes □ no □ unk		□ yes □ no □ unk
Constipation	□ yes □ no □ unk		□ yes □ no □ unk
Lymph node enlargement in groin	□ yes □ no □ unk		□ yes □ no □ unk
Ulcer Painful? □ yes □ no Site:_____	□ yes □ no □ unk		□ yes □ no □ unk
Papule Painful? □ yes □ no Site:_____	□ yes □ no □ unk		□ yes □ no □ unk
Fever	□ yes □ no □ unk		□ yes □ no □ unk
Weight Loss	□ yes □ no □ unk		□ yes □ no □ unk
Anal Spasms (cramping)	□ yes □ no □ unk		□ yes □ no □ unk
Other:_____	□ yes □ no □ unk		□ yes □ no □ unk

12. Clinical Exam Findings (Check all that apply) :

□ Inguinal Lymphadenopathy (Bubo) □ unilateral □ bilateral □ tender at adenopathy site	□ Mucous or purulent anal discharge	Rectal exam (digital), findings (if done): _____ _____ _____
□ Ulcer Tender? □ yes □ no Site:_____	□ Rectal bleeding	Anoscopy/Proctoscopy Done ? □ yes □ no □ unk Findings/Visualization :_____ _____ _____
□ Papule Tender ? □ yes □ no Site:_____	□ Fever	
□ Other (List) :_____	□ Weight loss	Sigmoidoscopy Done? □ yes □ no □ unk Findings/Visualization :_____ _____ _____

13. Was treatment given for suspected LGV ? □ yes □ no □ unknown
Drug:_____ Dose:_____ Frequency:_____ #Days:_____

14. Does the patient have a history of chlamydial infection in the past year (not including current diagnosis)? □ yes □ no □ don't know
14a. If yes, #1 Anatomic Site:_____ Date: M M - D D - Y Y Tx:_____
#2 Anatomic Site:_____ Date: M M - D D - Y Y Tx:_____

15. Patient's HIV Status : □ positive □ negative □ unknown Last Test, if known: M M - D D - Y Y

15a. If HIV+, Most recent CD4 Count:_____ Date: M M - D D - Y Y
Most recent Viral Load: _____ Date: M M - D D - Y Y

15b. If HIV+, is the patient receiving anti-retroviral therapy? □ yes □ no □ unknown

16. Check other STDs for which tests were conducted at the initial LGV clinic visit and test results, if available *(Check all that apply)*.

STD	Test Results	Test Type
☐ **Gonorrhea--Urine**	☐ positive ☐ negative ☐ unk	☐ NAATS ☐ unk
☐ **Gonorrhea--Rectal**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ NAATS
☐ **Gonorrhea--Oropharyngeal**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ NAATS
☐ **Trichomonas**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ wet mount
☐ **Syphilis—Non-Treponemal Test**	☐ reactive ☐ non-reactive ☐ unk Titer: _____/_____	☐ RPR ☐ VDRL ☐ Other_____ ☐ unk
☐ **Syphilis—Treponemal Test**	☐ reactive ☐ non-reactive ☐ unk	☐ FTA-ABS ☐ TP-PA ☐ Other_____ ☐ unk
☐ **Syphilis Ulcer/Chancre**	☐ positive ☐ negative ☐ unk	☐ Darkfield ☐ unk
☐ **Genital/Rectal Herpes**	☐ positive ☐ negative ☐ unk	☐ culture ☐ unk ☐ other_____
☐ **Hepatitis C**	☐ positive ☐ negative ☐ unk	☐ antibody ☐ unk ☐ PCR_____
☐ **Other**		

17. Chlamydia Diagnostic Tests at Visit for Suspected LGV :

CT Specimen Type/Lab	CT Test Results	Test Type (if known)
☐ **Urine** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ GenProbe Aptima ☐ Roche Amplicor ☐ BD ProbeTec ☐ Other:_____
☐ **Urethral Swab** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Antigen detection(specify):_____ ☐ Other(specify):_____
☐ **Rectal Swab #1** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Other (specify): _____ **Was specimen collected under direct visualization during anoscopy or sigmoidoscopy ?** ☐ yes ☐ no ☐ unknown
☐ **Rectal Swab #2** **Lab Name:** _____	☐ positive ☐ equivocal ☐ negative ☐ unknown	☐ Culture ☐ GenProbe Aptima ☐ GenProbe PACE ☐ BD ProbeTec ☐ Roche Amplicor ☐ unknown ☐ Other (specify): _____ **Was specimen collected under direct visualization during anoscopy or sigmoidoscopy ?** ☐ yes ☐ no ☐ unknown
☐ **Serology** **Lab Name:** _____	Titer (if known):____/____ Optical Density (if done):_____	☐ CF ☐ MIF ☐ EIA ☐ Other
☐ **Other:**_____ **Lab Name:**_____	Describe Results :	Describe Test Type:

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Patient's Sexual and Travel History (if available)

18. Did patient exchange sex for drugs or money in the past 60 days?
□ yes □ no □ unknown

19. Number of **male sex partners** the patient had in the past 60 days :_____

19a. Did the patient have sex (anal, vaginal) without a condom with any of these male partners? □ yes □ no □ unknown

19b. Did the patient have receptive anal intercourse with any of these male partners?
□ yes □ no □ unknown

19c. For male patients only: Did the patient have insertive anal intercourse with any of these male partners? □ yes □ no □ unknown

20. Number of **female sex partners** the patient had in the past 60 days :_____

For male patients only:

20a. Did the patient have insertive anal intercourse with any of these female partners?
□ yes □ no □ unknown

21. Did the patient travel outside the state where the clinic is located in the past 60 days (including international travel)? □ yes □ no □ unknown

21a. If yes, where did the patient travel (include dates)?
Location : _____ Dates :_____
Location : _____ Dates : _____

21b. Did the patient have sex with a person from that area or another traveler while there?
□ yes □ no □ unknown

If yes, which location and indicate if sex was with someone from the local area or a fellow traveler for each:
Location : _____ and contact:_____
Location : _____ and contact: _____

22. Did the patient report attending sex parties in the past 60 days? □ yes □ no □ unknown

23. Did the patient report using crystal methamphetamine in the past 60 days?
□ yes □ no □ unknown

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

Thank you for your time. Please fax this form to Katrina Park at (404) 639-8610 and to state and local health departments.