Massachusetts Department of Public Health

Bureau of Infectious Disease and Laboratory Sciences

Division of Surveillance, Analytics & Informatics

305 South Street, Jamaica Plain, MA 02130

*Phone: 617-983-6801 Confidential Fax:* 617-887-8789

To request **Partner Notification Services** for your patient, please call the Division of STD Prevention at **(617) 983-6940**

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| CHANCROID LYMPHOGRANULOMA VENEREUM (LGV) | | | | | **CASE REPORT FORM** | |
| GRANULOMA INGUINALE PID (AGENT UNKNOWN) | | | | | Version 5/16/2018  *For assistance filling out this form, call (617) 983-6801.* | |
|  | | | | | ***If you need help with this case, please call (617) 983-6940.*** | |
| **PATIENT INFORMATION**  Last First DOB: / / Med Rec #: Name: Name: Middle Initial: Social Security #: | | | | | | |
|  | | | | | Gender: Male Female Transgender Unknown | |
| Street Address: |  | Incarcerated  Homeless | | |
|  | Ethnicity: Hispanic/Latino Non-Hispanic Latino Unknown | |
| City: | Zip: | | | |
| Race: (check all that apply)  White Black Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native Other(specify): Unknown | |
| Cell Phone #: Home Phone #: | | | | |
| Primary Language Spoken: English Other(specify): | | | | |
| **CLINICAL INFORMATION** Diagnosis Date: / / | | | | | Pregnant: Yes No Unknown Not applicable | |
| Did the patient have any symptoms? Yes No Unknown | | | | |  | |
| If asymptomatic, why was the patient tested? Check all that apply.  Contact to STD Patient request Other | |
| If yes, what was the patient diagnosed with? | | | | |
|  | | | |  |
| Lab test, if performed (e.g. biopsy, culture, serology): | | | Specimen site: | | | Result: |
| Does the patient have sex with: Men Women Both Unknown  Has the patient exchanged money for sex and/or drugs? Yes No Unknown  Has the patient had sex while intoxicated and/or high? Yes No Unknown  Has the patient travelled out of the state in the last year? Yes (specify): No Unknown Has the patient been incarcerated in the last 60 days? Yes No Unknown  Other risk factors: | | | | | | |
| Treatment Start Date: / / Treatment: | | | | | | |
| **TESTING AGENCY INFORMATION**  Provider Name: Facility: Phone #:  Address: City: Zip: Fax: | | | | | | |
| Testing Setting:  Drug Treatment Facility Private Practice or HMO ER or Urgent Care  HIV Counseling, Testing, and Referral Site Community Health Center School-based Clinic including College/University Blood Bank Hospital-based Clinic Military/VA/Job Corps Clinic  Mental Health Services Site STD, HIV or Family Planning Clinic Correctional Institution  Other(specify): | | | | | | |
| **TREATING CLINICIAN INFORMATION (If different from testing agency):** Same as testing agency  Clinician Name: Facility: Phone #:  Address: City: Zip: Fax: | | | | | | |
| Clinician Practice Setting:  Private Practice or HMO STD, HIV, or Family Planning Clinic Military/VA/Job Corps Clinic Community Health Center ER or Urgent Care Correctional Institution  Hospital-based Clinic School-based Clinic including College/University Other(specify): | | | | | | |
| **ADMINISTRATIVE INFORMATION** Date Form Completed: / / Same as treating clinician  Name/Contact Information of person completing report (if not treating clinician): | | | | | | |