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:  |  | IncarceratedHomeless |
|  | 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):1.
2.
3.
 | Specimen site:1.
2.
3.
 | Result:1.
2.
3.
 |
| Does the patient have sex with: Men Women Both UnknownHas the patient exchanged money for sex and/or drugs? Yes No UnknownHas 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 UnknownOther 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 CareHIV Counseling, Testing, and Referral Site Community Health Center School-based Clinic including College/University Blood Bank Hospital-based Clinic Military/VA/Job Corps ClinicMental Health Services Site STD, HIV or Family Planning Clinic Correctional InstitutionOther(specify):  |
| **TREATING CLINICIAN INFORMATION (If different from testing agency):** Same as testing agencyClinician 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 InstitutionHospital-based Clinic School-based Clinic including College/University Other(specify):  |
| **ADMINISTRATIVE INFORMATION** Date Form Completed: / / Same as treating clinicianName/Contact Information of person completing report (if not treating clinician):  |