



Appendix I

LGV Enhanced Surveillance Form

Until recently, LGV has been a rare infection in industrialized countries, and was usually acquired from endemic areas. In light of recent cases, the Public Health Agency of Canada is coordinating national enhanced surveillance of LGV in an effort to rapidly identify and describe outbreaks in Canada. This form is intended to serve as a helpful tool for health care providers in collecting key epidemiological information on suspected cases.

1.	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Unknown
2.	Date of Birth:				
3.	City of Residence:				
4.	What ethnic origin does the patient consider him/herself to be?				
5.	Date of clinic visit: (yyyy/mm/dd)				
6.	Date of onset of LGV symptoms: (yyyy/mm/dd)				
7.	Date of 1 st presentation at the clinic for this episode: (yyyy/mm/dd)				
8.	What were the patient's presenting symptoms? Please mark an answer for each:				
		Yes	No	Unknown	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctitis
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaise
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal lymphadenopathy
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital papule/lesion
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stools
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify): _____
9.	Has the patient experienced any of the following symptoms? Please mark an answer for each:				
		Yes	No	Unknown	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proctitis
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaise
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal lymphadenopathy
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital papule/lesion
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stools
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify): _____ _____

<p>10.</p>	<p>How does the patient define him/herself?</p> <p> <input type="checkbox"/> Gay or homosexual <input type="checkbox"/> Two spirited <input type="checkbox"/> Bisexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Other _____ </p>																																												
<p>11.</p>	<p>At the time the individual was infected with LGV, was he/she co-infected with any of the following? If yes, please provide the date of that diagnosis:</p> <table border="0"> <thead> <tr> <th>Yes</th> <th>No</th> <th>Unknown</th> <th>Date of diagnosis _____</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>None</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital warts/HPV _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Gonorrhoea _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital Herpes _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chlamydia (not LGV) _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Syphilis _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HIV _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hepatitis C _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hepatitis B _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other _____</td> </tr> </tbody> </table>	Yes	No	Unknown	Date of diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhoea _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia (not LGV) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
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<p>11a.</p>	<p>If Hepatitis C positive, was the infection:</p> <p>Acute <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Chronic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																												
<p>11b.</p>	<p>If Hepatitis B positive, was the infection:</p> <p>Acute <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Chronic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																												
<p>12.</p>	<p>Was the patient Hepatitis C antibody positive?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, the date of this test: (yyyy/mm/dd) _____</p>																																												
<p>13.</p>	<p>Was the patient Hepatitis C PCR positive?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, the date of this test: (yyyy/mm/dd) _____</p>																																												
<p>14.</p>	<p>Has the patient engaged in drug use with shared needles, spoons, straws and other drug-related equipment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																												

15.	<p>Does the patient have a history of blood transfusion or blood product receipt prior to 1992?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
16.	<p>Has the patient had tattooing or body piercing with dirty or un-sterile needles and ink?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
17.	<p>Has the patient engaged in sexual activities where exchange of blood may have occurred (sex during menstruation/S&M/unprotected anal or rough sex)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
18.	<p>During any travel outside of the reporting jurisdiction in the 60 days prior to symptom onset, did the case have sex with a person from the area of travel or another traveler while there?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, city/geographic location: _____</p>
19.	<p>Up to 60 days prior to the onset of LGV symptoms, what was the circumstance(s) in which sexual activity took place? (Tick all that apply)</p> <p><input type="checkbox"/> No sexual contacts 60 days prior to LGV symptoms <input type="checkbox"/> Private residence</p> <p><input type="checkbox"/> Rave/circuit party <input type="checkbox"/> Sex trade</p> <p><input type="checkbox"/> Leather scene party <input type="checkbox"/> Internet partnering</p> <p><input type="checkbox"/> Bathhouse/sauna <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other, please specify: _____</p>
20.	<p>How many sexual partners did the patient have in the 60 days prior to the onset of LGV symptoms?</p> <p>Total number of female sexual partners: _____</p> <p>Total number of male sexual partners: _____</p>
21.	<p>Has the patient ever had a sexual partner with known LGV infection?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, a femal partner</p> <p><input type="checkbox"/> Yes, a male partner <input type="checkbox"/> Unknown</p>
22.	<p>If the patient had a sexual partner with known LGV, does he or she recall when the sexual contact took place?</p> <p>_____</p> <p>_____</p>
23.	<p>In the 60 days prior to the onset of LGV symptoms, did the patient engage in the following activities:</p> <p>Rectal enema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Rectal use of recreational drugs <input type="checkbox"/>* Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>*If yes, which drug(s) were used rectally: _____</p>

24. Please indicate if the patient engaged in any of the following, within 60 days prior to the onset of LGV symptoms: "Protected" refers to the use of condoms or other barrier methods.

	No	Yes, protected	Yes, unprotected	Unknown
Receptive anal intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertive anal intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptive oral sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertive oral sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing sex toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptive fisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertive fisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other relevant sexual activity (Please specify): _____

25. Type of lab test(s) done and results:

Type of test	Specimen (including site)	Date of Collection (yyyy/mm/dd)	Results
Non-specific Culture for <i>C. trachomatis</i>			<input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> unknown
NAAT for <i>C. trachomatis</i>			<input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> unknown
Serology Microimmunoflourescence (MIF)			Titre:
Complement Fixation (CF)			Titre:
Confirmatory DNA Sequencing			<input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> unknown Serovar: <input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L2b <input type="checkbox"/> L3
RFLP			<input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> unknown Serovar: <input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L2b <input type="checkbox"/> L3
Other (Please specify): _____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____