**Lung Injury Associated with E-cigarette Use or Vaping | National Case Report Form – Standard Version**

CDC is investigating cases of unexplained lung injury associated with electronic cigarette use or vaping as detailed in CDC’s Health Advisory (<https://emergency.cdc.gov/han/han00421.asp>). Local and state health departments should complete this form for any probable or confirmed case patient (see [case definition](https://www.cdc.gov/tobacco/basic_information/e-cigarettes/assets/2019-Lung-Injury-Surveillance-Case-Definition-508.pdf)) and transmit data to CDC using DCIPHER or by contacting CDC State Points of Contact.

Case ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case status  Probable  Confirmed Died?  Yes  No If yes, date of death \_\_\_\_\_\_\_\_\_\_\_\_\_ (*see clinical section)*

Was patient hospitalized?  Yes  No If yes, hospitalization date \_\_\_\_\_\_\_\_\_\_ Discharge date \_\_\_\_\_\_\_\_

Date reported to public health department Name of Public Health Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing form Contact phone number

**PART I: PATIENT DEMOGRAPHICS AND EXPOSURES**

**Patient Demographics**

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Male  Female

Age \_\_\_\_\_\_\_\_\_years

Ethnicity Hispanic  Non-Hispanic

Race (Select all that apply) White Black American Indian/Alaska Native Asian Native Hawaiian or Other Pacific Islander

**Patient Substance Use in the Past 3 Months (90 days)**

Any **e-Cigarette** use or **vaping** (e.g., vaping, dabbing)?  Yes  No  Refused to answer

If yes, substance(s) vaped or dabbed in past 3 months?

Nicotine  Marijuana, THC oil, THC concentrates, hash oil, wax  Cannabidiol (CBD)  Synthetic Cannabinoids  Flavors alone

Other substances, specify \_\_\_\_\_  Unknown

Any combustible tobacco smoking (i.e. any non-vape nicotine product e.g., cigarettes, cigars)? Yes No Any other tobacco products (e.g., smokeless tobacco)? Yes No

Any combustible marijuana smoking (i.e., any non-vape marijuana)? Yes No Any other marijuana products (e.g., edibles)? Yes No

**Nicotine E-cigarette or Vaping Use in the Past 3 Months (90 days)**

Any **nicotine** e-cigarette use or vaping reported?  Yes  No  Unknown Date last used

If yes, what is the frequency of use?  Daily  A few times per week, specify: \_\_\_\_\_\_\_\_\_  A few times per month, specify \_\_\_\_\_\_  Monthly or less

If yes and daily use, on average, how many times per day? \_\_\_\_\_\_\_\_\_\_

Did patient report vaping flavoured nicotine in e-Cigarette and/or vape product(s)?  Yes  No

How many brands of nicotine containing products vaped or dabbed in the past 3 months? \_\_\_\_\_ *[enter whole number]*

Where was the **nicotine** e-Cigarette(s) or vaping product(s) purchased or obtained? *Check all that apply*

Recreational dispensary  Vape or smoke shop  Pop-up shop  Grocery store/drugstore/Convenience store  Family or friend

Dealer  Online  Other, describe \_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of device(s) were used with this nicotine product? *Select all that apply*

Disposable e-cigarette or vaping device  E-cigarettes with pre-filled or refillable cartridges (e.g., using battery pens, Ego, EVO, Ooze

pen, Caliplug, 510 battery)  E-cigarette with tank that you refill with liquids (including sub-ohm, mod or modifiable systems)

E-cigarettes with pre-filled or refillable “pods” or pod cartridges (e.g. JUUL, Suorin)  Other, describe \_\_\_\_\_\_\_\_\_\_\_

Were any of these nicotine devices a mod device (a device that allows user to choose higher and/or variable temperatures)?  Yes  No  Unknown

Did patient modify, or add a substance to, the nicotine device(s) that was not intended by the manufacturer?  Yes  No ☐ Unknown

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient know anyone else who became ill from vaping **nicotine**? Yes No

If yes, were **nicotine** products or devices shared with that person? Yes No

Product sample sent for testing?  Yes  No If yes, where was sample tested \_ Product sample ID number(s) \_\_\_\_\_\_\_\_\_\_

**THC E-cigarette or Vaping Use in the Past 3 Months (90 days)**

Any **THC** e-cigarette use or vaping reported?  Yes  No  Unknown Date last used

If yes, what is the frequency of use?  Daily  A few times per week, specify: \_\_\_\_\_\_\_\_\_  A few times per month, specify\_\_\_\_\_\_\_\_  Monthly or less

If yes, on average, how many times per day? \_\_\_\_\_\_\_\_\_\_

Did patient report vaping flavoured THC in e-cigarette and/or vape product(s)?  Yes  No

How many brands of THC containing products vaped or dabbed in the past 3 months? \_\_\_\_\_ *[enter whole number]*

What was the purpose of THC product(s) used?  medical purposes  nonmedical (recreational) purposes  other, specify \_\_\_\_

Which THC substance(s) were used in an e-cigarette, vaping device, vaporizer, or dab rig? *Select all that apply*

Marijuana herb THC oils Butane hash oil THC concentrate (e.g., wax, batter/budder, crumble, shatter, pull and snap)

☐THC powder (e.g., dry sift)  Other, describe \_\_\_\_\_\_\_\_\_\_\_

Where was the **THC** e-cigarette(s) or vaping product(s) purchased or obtained? *Check all that apply*

Medical dispensary  Recreational dispensary (retail cannabis/marijuana shop)  Vape or smoke shop  Pop-up shop

Grocery store/Drugstore/Convenience store  Family or friend  Illicit dealer  Online  Other, describe \_\_\_\_\_\_\_\_\_\_

What kind of device(s) were used with this substance? *Select all that apply*

Disposable device  Device with pre-filled cartridges  Device with tank that you refill with liquids (e.g., mods)

Device with pre-filled or refillable “pods” or pod cartridges (e.g. JUUL, Suorin)  Dab rig  Vaporizer (for dry herbs, etc.)  Other \_\_\_\_

What brand of THC cartridge(s) were used with device(s) (Check all that apply):  Rove  Dank Vapes  Golden Gorilla  Smart Cart  Other \_\_\_\_\_\_\_\_\_\_\_\_

Was this a mod device (a device that allows user to choose higher and/or variable temperatures)?  Yes  No  Unknown

Did patient modify, or add a substance to, the device(s) that was not intended by the manufacturer?  Yes  No  Unknown

If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient know anyone else who became ill from vaping **THC**? Yes No

If yes, were **THC** products or devices shared with that person? Yes No

Product sample sent for testing?  Yes  No If yes, where was sample tested \_ Product sample ID number(s) \_\_\_\_\_\_

**PART II: CLINICAL INFORMATION**

**Symptoms at Initial Presentation to First Encounter to Medical Care**

Chief complaint Date symptom(s) started

GI symptoms?  Yes  No  Unknown If yes, describe \_\_\_\_\_\_\_\_\_

Respiratory symptoms?  Yes  No  Unknown If yes, describe \_\_\_\_\_\_\_\_\_

Constitutional symptoms?  Yes  No  Unknown If yes, describe \_\_\_\_\_\_\_\_\_\_

(e.g., fever, chills, malaise)

Weight loss during current illness?  Yes  No  Unknown If yes, amount (lb)

**Medical History**

Chronic respiratory disease (including asthma, COPD, etc.)?  Yes  No If yes, specify type of disease

Heart disease?  Yes  No If yes, specify type of disease

Anxiety?  Yes  No

Depression?  Yes  No

Other chronic illness?  Yes  No If yes, specify type of chronic illness

Pregnant?  Yes  No  Unknown If yes, trimester  First  Second  Third  Unknown

**Imaging**

CT performed  Yes  No If yes, location of abnormal findings  Bilateral  Right  Left  Normal (no findings)

If yes, infiltrates/opacities present  Yes  No Subpleural sparing  Yes  No  Unknown

Chest X-ray performed  Yes  No If yes, location of abnormal findings  Bilateral  Right  Left  Normal (no findings)

If yes, infiltrates/opacities present  Yes  No

Specify other abnormal chest imaging findings (e.g., pneumothorax)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infectious Disease Testing**

Respiratory viral panel  Positive (specify \_\_\_\_\_\_\_\_\_ )  Negative  Pending  Not done

Influenza  Positive (specify \_\_\_\_\_\_\_\_\_ )  Negative  Pending  Not done

Blood cultures  Positive (specify organisms\_\_\_\_\_)  Negative  Pending  Not done

Legionella urinary antigen  Positive  Negative  Pending  Not done

Strep pneumoniae urinary antigen  Positive  Negative  Pending  Not done

Mycoplasma pneumoniae  Positive (specify \_\_\_\_\_\_\_\_\_ )  Negative  Pending  Not done

Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Positive (specify \_\_\_\_\_\_\_\_\_ )  Negative  Pending  Not done

**Clinical Course of Lung Injury**

Is this the first time patient is presenting for medical care for these symptoms?  Yes  No

If yes, is a follow-up visit scheduled?  Yes  No

Was patient hypoxemic (<95) at any outpatient visit or at any point during hospitalization?  Yes  No If yes, date(s)\_\_\_\_\_\_\_\_ Lowest value:\_\_\_\_\_\_\_\_\_

Outpatient visit #1  Yes  No

If yes, date of visit \_\_\_\_\_\_\_

Outpatient visit #2  Yes  No

If yes, date of visit \_\_\_\_\_\_

Were there additional outpatient/clinic visits?  Yes  No

If yes, specify number of additional visits \_\_\_\_\_\_\_

Urgent care visit #1  Yes  No

If yes, date of visit \_\_\_\_

Urgent care visit #2  Yes  No

If yes, date of visit \_\_\_\_\_\_\_

Were there additional urgent care visits?  Yes  No

If yes, specify number of additional visits \_\_\_\_\_\_\_

Emergency Department (ED) visit #1  Yes  No

If yes, date of visit \_\_\_\_\_\_\_

ED visit #2  Yes  No

If yes, date of visit\_\_\_\_

Were there additional ED visits?  Yes  No

If yes, specify number of additional visits \_\_\_\_\_\_\_

If hospitalized, was patient re-hospitalized at a later date?  Yes  No If yes, hospitalization date \_\_\_\_\_\_\_\_\_\_ Discharge date \_\_\_\_\_\_\_\_

Were there additional hospitalizations?  Yes  No If yes, specify number of additional hospitalizations \_\_\_\_\_\_\_

ICU Admission  Yes  No If yes, ICU admission date \_\_\_\_\_\_\_\_\_ ICU duration (in days) \_\_\_\_\_\_\_\_\_\_

Treated with steroids?  Yes  No If yes, medication(s): \_\_\_\_\_\_\_\_ dose: \_\_\_\_ start date:\_\_\_\_\_\_ duration: \_\_  Taper

Treated with antibiotics?  Yes  No If yes, medication(s): \_\_\_\_\_\_\_\_ dose: \_\_\_\_ start date:\_\_\_\_\_\_ duration:\_\_\_\_\_\_\_\_

Treated with antivirals?  Yes  No If yes, medication(s): \_\_\_\_\_\_\_\_ dose: \_\_\_ \_ start date:\_\_\_\_\_\_ duration:\_\_\_\_\_\_\_\_

Required respiratory support?  Yes  No  Intubated (duration\_\_\_\_\_\_\_\_\_)  BiPAP/CPAP/High flow  Supplemental oxygen

Required ECMO (Extracorporeal membrane oxygenation)?  Yes (duration\_\_\_\_\_\_\_\_\_)  No

**Clinical specimens**

Bronchoalveolar lavage performed?  Yes, date of sample\_\_\_\_\_  No If yes, where tested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen ID \_\_\_\_\_\_\_

If yes, lipid staining  Yes  No

If yes, lipid-laden macrophages seen  Yes  No

Blood sample testing performed?  Yes, date of sample \_\_\_\_  No If yes, where tested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen ID \_\_\_\_\_\_\_

Urine sample testing performed?  Yes, date of sample \_\_\_\_  No If yes, where tested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen ID \_\_\_\_\_\_\_

Lung biopsy performed?  Yes, date of sample \_\_\_\_  No If yes, where tested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specimen ID \_\_\_\_\_\_\_

If yes, lipid staining?  Yes  No

If yes, lipid-laden macrophages seen?  Yes  No

If yes, findings consistent with acute lung injury?  Yes  No If no, specify findings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, other significant findings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Death Information**

Died  Yes  No If yes, specify location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediate cause of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contributing causes of death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autopsy performed?  Yes  No If yes, autopsy sample collected  Yes  No If yes, where tested\_\_\_\_\_\_ Specimen ID \_\_\_\_\_\_\_\_

If yes, lipid staining performed on autopsy lung tissue?  Yes  No If yes, lipid-laden macrophages seen?  Yes  No

If yes, findings consistent with acute lung injury?  Yes  No If no, specify findings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, other significant autopsy findings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*National Case Report Form v.02 Last updated October 31, 201*