**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*