Form Approved
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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) 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 <u>Past 3 Months (90 days)</u>
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 _____