**Lung Injury Associated with E-cigarette Use or Vaping (EVALI)** **|** **National Case Report Form – Abbreviated Version**

Clinicians should complete this form for any confirmed or probable hospitalized EVALI case and send to their local and/or state health department.

Medical Record Number \_\_\_\_\_

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

Person completing form Contact phone number

**PART I. CASE CLASSIFICATION** (see [www.cdc.gov/lunginjury](http://www.cdc.gov/lunginjury) for full case definition)

All cases must have:

* e-cigarette or dabbing history in the 90 days prior to symptom onset
* radiologic findings (infiltrates on chest Xray or ground-glass opacities on CT)
* no evidence of alternative plausible diagnoses (eg, cardiac, rheumatologic, neoplastic)

If 1 and 2 are Yes 🡪 **confirmed case**

If infectious work up not done or infection identified but not felt to be the sole cause of lung injury 🡪 **probable case**

Determining confirmed vs. probable case status:

1. Was an infectious work up done?\*  Yes  No
2. Was infectious work up negative?  Yes  No

*\*Including respiratory viral panel, influenza testing, and other clinically-indicated respiratory infectious disease testing*

**Case status**  Confirmed  Probable

**PART II: 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)**

In the past 3 months, has the patient…

Used any e-cigarette or vaping products (e.g., vaping, dabbing)?  Yes  No *(Note: All cases should have Yes response)*

Vaped or dabbed the following substances:

Nicotine?  Yes  No  Unknown

Marijuana, THC oil, THC concentrates, hash oil, wax?  Yes  No  Unknown

Other substances? (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Yes  No  Unknown

*(e.g. cannabidiol (CBD), synthetic cannabinoids, flavors alone)*

**PART III: CLINICAL INFORMATION**

**Clinical Course of Lung Injury**

Hospital admission date \_\_\_\_\_\_\_\_\_\_\_\_

Hospital discharge date \_\_\_\_\_\_\_\_\_\_\_\_

Was patient hypoxemic (<95%) at any point during this hospitalization?  Yes  No

During this hospitalization, was the patient:

Treated with steroids?  Yes  No

Treated with antibiotics?  Yes  No

Treated with antivirals?  Yes  No

Admitted to the ICU?  Yes  No

Intubated?  Yes  No

On BiPAP/CPAP/High Flow?  Yes  No

On ECMO?  Yes  No

**Symptoms at Presentation to Medical Care**

Date symptom(s) started \_\_\_\_\_\_\_\_\_\_\_\_\_

GI symptoms?  Yes  No  Unknown

Respiratory symptoms?  Yes  No  Unknown

Constitutional symptoms?  Yes  No  Unknown

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

Weight loss?  Yes  No  Unknown

**Medical History**

Chronic respiratory disease (asthma, COPD, etc.)?  Yes  No

Heart disease?  Yes  No

Anxiety?  Yes  No

Depression?  Yes  No

Other chronic illness?  Yes  No specify: \_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant?  Yes  No  Unknown

Prior hospitalization for EVALI?  Yes  No

**Investigations**

Influenza testing  Positive Negative  Pending  Not done

Bronchoalveolar lavage 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 \_\_\_\_\_\_\_

**Imaging**

|  |  |  |
| --- | --- | --- |
|  | **Chest X-ray performed**  Yes  No  ***If yes, findings:*** | **Chest CT performed**  Yes  No  ***If yes, findings:*** |
| Location of findings | ☐ Bilateral ☐ Right ☐ Left ☐ Normal | ☐ Bilateral ☐ Right ☐ Left ☐ Normal |
| Infiltrates/opacities present | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Specify other abnormal findings (eg, pneumothorax) |  |  |

**Death Information**

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

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