**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 \_\_\_\_\_\_\_\_