Form Approved
OMB # 0920-1011
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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______________________
Person completing form ____

Name of Public Health Department_____________________
Contact phone number _________________________________

PART I. CASE CLASSIFICATION (see 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)

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*

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**

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

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

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

CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

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 ________