Form Approved
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SEVERE PULMONARY DISEASE ASSOCIATED WITH E-CIGARETTE USE OUTBREAK

NATIONAL CASE REPORT FORM (CDC)

October 31, 2019

Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data 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 Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Centers for Disease Control and Prevention

Lung Injury Associated with E-cigarette Use or Vaping | National Case Report Form

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 ☐ Other Age __________years

Race ☐White ☐Black ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Other

Ethnicity ☐Hispanic ☐ Non-Hispanic

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 (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

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 [Skip logic: 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 substance? *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 ____________

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 **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) ___________

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 [Skip logic: 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) use? ☐ 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): ☐ 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 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	☐ Positive (specify _________)	☐ Negative	☐ Pending	☐ Not done

Clinical Course of Lung Injury

Is this the first time patient is presenting for clinical 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 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 ___________________

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Specimen Manifest Form

CDC Case ID (note: this is used by state epidemiologists when submitting case data to CDC)	State Case ID	Sample ID	Matrix (urine, whole blood, serum, plasma, BAL, etc)	Box # or ID	Position in Box	Volume (mL)	Collection Date	Any pertinent comments (hemolyzed sample, clotted sample, etc)

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