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.

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 ☐Other

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, any e-Cigarette use or vaping in the past 30 days? ☐Yes ☐No
If yes, substance(s) used in past 3 months (90 days)?
☐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 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 using 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
☐Medical dispensary ☐Recreational dispensary (retail cannabis/marijuana shop) ☐Vape shop ☐Pop-up shop
☐Convenience store/gas station ☐Family or friend ☐Illicit dealer ☐Online ☐Other, describe ______________
What kind of device(s) were used with this product? Select all that apply
☐Disposable e-cigarette ☐E-cigarettes with pre-filled cartridges ☐E-cigarette with tank that you refill with liquids (e.g, mods)
☐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 ______________

Did patient share product with anyone who became ill? ☐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 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 using 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 shop ☐Pop-up shop
☐Convenience store/gas station ☐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 ☐Unknown

What kind 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 ______________

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
Chest imaging performed ☐ CT chest ☐ Chest X-ray ☐ Both
Location of abnormal findings ☐ Bilateral ☐ Right ☐ Left ☐ Normal (no findings)
Infiltrates/opacities present ☐ Yes ☐ No
Subpleural sparing on CT ☐ Yes ☐ No ☐ Unknown
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 __________________________

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 at any outpatient, urgent care or ED visit? ☐ 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 ______
Hospitalization #1 ☐ Yes ☐ No If yes, hospitalization date_________ Discharge date_______
Hospitalization #2 ☐ 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:_________ dose:____ start date:____ duration:____ ☐ Taper
Treated with antibiotics? ☐ Yes ☐ No If yes, medication:_________ dose:____ start date:____ duration:____
Treated with antivirals? ☐ Yes ☐ No If yes, medication:_________ dose:____ start date:____ duration:____
Required respiratory support? ☐ Intubated (duration_______) ☐ BiPAP/CPAP/High flow
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 available for testing? ☐ Yes, date of sample____ No If yes, where tested __________________________ Specimen ID_______
Urine sample available for testing? ☐ 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____________________________