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.

CDC Case ID Number ________________________ Medical Record Number __________________________________
Case status ☐ Probable ☐ Confirmed Died? ☐ Yes ☐ No If yes, date of death ____________ (*see clinical section)*
Date form completed _____________________________ 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 ☐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 month (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 ____
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 ___________________