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 _____