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 EXPOSURE

Patient Demographics

County __________________        State _____________________
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, 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?

☐ 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 pneumoniea urinary antigen □ Positive □ Negative □ Pending □ Not done ____________________________
Mycoplasma pneumoniea □ 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 hypoxicemc 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 ____________________________ ____________________________