

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 _____