Lung Injury Associated with Vaping or E-cigarette Use

County

Case name (last, first) ____________________
Birth date ___/___/___ Sex ☐ F ☐ M ☐ Other Alternate name ____________
Phone ____________ Email ____________
Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work
Street address ____________________
City/State/Zip ____________________
Residence type (incl. Homeless) ____________ WA resident ☐ Yes ☐ No
Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other ____________
Contact name ____________ Contact phone ____________

ADMINISTRATIVE

LHJ Case ID ____________
Investigator name (last, first) ____________
Investigator contact phone ____________
Medical Record Number____________
LHJ notification date ___/___/___
Classification ☐ Confirmed ☐ Under Investigation
☐ Not reportable ☐ Probable
Investigation status
☐ In progress
☐ Complete
☐ Unable to complete
Investigation start date ___/___/___
Investigation complete date ___/___/___
Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID __________Cluster Name ____________

ADDITIONAL PERSON INFORMATION

It is preferable to collect this information directly from patient.
Age at symptom onset (years)?________
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk
Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other (specify):____________

COMMUNICATION

Primary HCP name ____________
Phone ____________

OK to talk to patient? (If later, provide time and date)
☐ Yes ☐ Later ____AM/PM ___/___/___ ☐ Never
(See also alternate contact information at top of record)
Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach
☐ Patient could not be interviewed

REPORT SOURCE

Initial report source (refer to options at right) ____________
LHJ ____________
Reporter organization ____________
Reporter name ____________
Reporter phone ____________

All reporting sources (check all that apply)
☐ Citizen ☐ Health care facility/representative ☐ Health care provider ☐ ID'd through investigation ☐ Other state
☐ Death cert ☐ Other ____________

CLINICAL INFORMATION

Symptom Onset ____/____/____ Chief complaint____________________

Symptoms at Initial Presentation to Medical Care

Y	N	Unk		
☐	☐	☐	GI Symptoms	If yes, describe____________
☐	☐	☐	Respiratory symptoms	If yes, describe____________
☐	☐	☐	Constitutional symptoms	If yes, describe____________
☐	☐	☐	Weight loss during current illness	If yes, amount (lbs)____________

Medical History

Y	N	Unk	
☐	☐	☐	Chronic respiratory disease (including asthma, COPD, etc.) If yes, specify ____________
☐	☐	☐	Cardiac disease If yes, specify ____________
☐	☐	☐	Anxiety
☐	☐	☐	Depression
☐	☐	☐	Other chronic illness If yes, specify ____________
☐	☐	☐	Pregnant Trimester: ☐ First ☐ Second ☐ Third ☐ Unk

Imaging

CT performed ☐ Yes ☐ No If yes, location of abnormal findings ☐ Bilateral ☐ Right ☐ Left ☐ Normal (no findings)

If yes, infiltrates/opacities present: ☐ Yes ☐ No Subpleural sparing: ☐ Yes ☐ No ☐ Unknown

Chest X-ray performed ☐ Yes ☐ No If yes, location of abnormal findings ☐ Bilateral ☐ Right ☐ Left ☐ Normal (no findings)

If yes, infiltrates/opacities present: ☐ Yes ☐ No

Specify other abnormal chest imaging findings (e.g., pneumothorax)____

Infectious Disease Testing

Pos	Neg	Pending	No Test	Test	
☐	☐	☐	☐	Respiratory viral panel	If Positive, specify ____
☐	☐	☐	☐	Influenza	If Positive, specify: ☐ Type A ☐ Type B ☐ Not typed
☐	☐	☐	☐	Blood cultures	If Positive, specify organisms___________________________________
☐	☐	☐	☐	Legionella urinary antigen	
☐	☐	☐	☐	Strep pneumoniae urinary antigen	
☐	☐	☐	☐	Mycoplasma pneumoniae	If Positive, specify ____________________________________
☐	☐	☐		Other, specify test ____________________________	If Positive, specify______________________
☐	☐	☐		Other, specify test ____________________________	If Positive, specify______________________
☐	☐	☐		Other, specify test ____________________________	If Positive, specify______________________

Clinical Course of Lung Injury *(only clinical information related to lung injury)*

Yes	No	Unk	
☐	☐	☐	Was this the first time patient is presenting for clinical care for these symptoms?
☐	☐	☐	If yes, was a follow-up visit scheduled?
☐	☐	☐	Was patient hypoxemic (<95) at any outpatient, urgent care, hospitalization, or ED visit? If yes, date(s)_____________

Lowest value: ____

Yes	No	Unk	
			Outpatient / Clinic
☐	☐	☐	Outpatient visit #1 If yes, date of visit ___/____/____
☐	☐	☐	Outpatient visit #2 If yes, date of visit ___/____/____
☐	☐	☐	Were there additional outpatient/clinic visits? If yes, specify number of additional visits _______
			Urgent Care
☐	☐	☐	Urgent care visit #1 If yes, date of visit ___/____/____
☐	☐	☐	Urgent care visit #2 If yes, date of visit ___/____/____
☐	☐	☐	Were there additional urgent care visits? If yes, specify number of additional visits _______
			Emergency Department
☐	☐	☐	Emergency Department (ED) visit #1 If yes, date of visit ___/____/____
☐	☐	☐	Emergency Department (ED) visit #2 If yes, date of visit ___/____/____
☐	☐	☐	Were there additional ED visits? If yes, number of additional visits _______
			Hospitalizations & ICU
☐	☐	☐	Hospitalization #1 If yes, hospitalization date ___/____/____ Discharge date ___/____/____
☐	☐	☐	Hospitalization #2 If yes, hospitalization date ___/____/____ Discharge date ___/____/____
☐	☐	☐	Were there additional hospitalizations? If yes, number of additional hospitalizations _______
☐	☐	☐	ICU Admission If yes, ICU admission date ___/____/____ Duration (in days) _____

Treatment

Yes	No	Unk					
☐	☐	☐	Treated with steroids? Medication: ____________	dose: ____	start date:______	duration: ________	☐ Taper
			Medication: _______________________	dose: ____	start date:______	duration: ________	☐ Taper
			Medication: _______________________	dose: ____	start date:______	duration: ________	☐ Taper
			Medication: _______________________	dose: ____	start date:______	duration: ________	☐ Taper
☐	☐	☐	Treated with antibiotics? Medication: ____________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
☐	☐	☐	Treated with antivirals? Medication: ____________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	
			Medication: _______________________	dose: ____	start date:______	duration: ________	

☐ ☐ ☐ Required respiratory support? ☐ Intubated (duration_________) ☐ BiPAP/CPAP/High flow
☐ Supplemental oxygen

☐ ☐ ☐ Required ECMO (Extracorporeal membrane oxygenation)? If Yes (duration_________)

Clinical specimens

Y N Unk	Diagnostic samples gathered	Date of sample	Investigation samples	Specimen ID
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	**Bronchoalveolar lavage performed?** If yes, lipid staining? If yes, lipid-laden macrophages seen? Other report findings: ____________ ______________________________	___/____/____	Stored at ________ ___________________ Date sent to WA DOH PHL: ___/____/____	Specimen ID: ___________________ Tested at: ☐ CDC ☐ Hospital Lab ☐ Private Lab ☐ Other PHL: ___________________
☐ ☐ ☐	Blood sample testing performed? *(only include sampling related to the investigation)*	___/____/____	Stored at ________ ___________________ Date sent to WA DOH PHL: ___/____/____	Specimen ID: ___________________ Tested at: ☐ CDC ☐ Hospital Lab ☐ Private Lab ☐ Other PHL: ___________________
☐ ☐ ☐	Urine sample testing performed? *(only include sampling related to the investigation)*	___/____/____	Stored at ________ ___________________ Date sent to WA DOH PHL: ___/____/____	Specimen ID: ___________________ Tested at: ☐ CDC ☐ Hospital Lab ☐ Private Lab ☐ Other PHL: ___________________
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ N → Y →	Lung biopsy performed? If yes, lipid staining? If yes, lipid-laden macrophages seen? If yes, findings consistent with acute lung injury? If no, specify findings: If yes, other significant findings:	___/____/____	Stored at ________ ___________________ Date sent to WA DOH PHL: ___/____/____	Specimen ID: ___________________ Tested at: ☐ CDC ☐ Hospital Lab ☐ Private Lab ☐ Other PHL: ___________________

DEATH INFORMATION

Y N Unk

☐ ☐ ☐ **Died? Death date ___ /___/____**

☐ ☐ ☐ Autopsy performed?

☐ ☐ ☐ Autopsy sample collected? Date collected: ___ /___/____

☐ ☐ ☐ If yes, lipid staining?

☐ ☐ ☐ If yes, lipid-laden macrophages seen?

☐ ☐ ☐ If yes, findings consistent with acute lung injury?

→ If no, specify findings:

→ If yes, other significant autopsy findings:

Autopsy specimen testing information

Stored at ________
____

Date sent to WA DOH PHL:
___/____/____

Specimen ID:
____

Tested at:
☐ CDC
☐ Hospital Lab
☐ Private Lab
☐ Other PHL:
____

Location of death: ☐ At home ☐ Dead on arrival in emergency department ☐ Emergency department ☐ Inpatient ☐ Unknown ☐ Other ________________________________

Immediate cause of death________________________________

Contributing causes of death________________________________

EXPOSURE INFORMATION

Patient Substance Use in the Past 3 Months (90 Days)

E-Cigarette/Tobacco Products

Question	Response
Any **e-Cigarette** use or **vaping** (e.g., vaping, dabbing)?	☐ Yes ☐ No ☐ DK ☐ Refused

If yes, substance(s) used for vaping. Check all that apply:
☐ Nicotine ☐ Marijuana, THC oil, THC concentrates, hash oil, wax ☐ Cannabidiol (CBD)
☐ Synthetic Cannabinoids (e.g., spice, K2) ☐ Flavors alone
☐ Other substances, specify: ________________ ☐ Unknown

Question	Response
Any combustible tobacco smoking (e.g., cigarettes, cigars)?	☐ Yes ☐ No ☐ DK ☐ Refused
Any other tobacco products used (e.g., smokeless tobacco)?	☐ Yes ☐ No ☐ DK ☐ Refused
Any combustible marijuana smoking (i.e., any non-vape marijuana)?	☐ Yes ☐ No ☐ DK ☐ Refused
Any other marijuana products used (e.g., edibles, tincture)? Specify: ______________________________________	☐ Yes ☐ No ☐ DK ☐ Refused

Nicotine Products

Question	Response
Any nicotine e-cigarette or vaping?	☐ Yes ☐ No ☐ DK ☐ Refused If No, DK, Refused go to THC Section

Date last vaped nicotine: ___ / ___ / ___
How frequently did you vape nicotine? ☐ Daily ☐ Few times/ week ☐ Few times/ month ☐ Monthly or less
On average, how many times… per day ___ per week ___ per month ___

Question	Response
Any use of **flavored** nicotine in e-Cigarette and/or vape product(s)?	☐ Yes ☐ No ☐ DK ☐ Refused
How many brands of nicotine containing products vaped or dabbed in the past 3 months?	_____ (whole #) ☐ Refused

What are the brands or names of nicotine containing products vaped in the past 3 months? List as many as can be remembered:

Where was the **nicotine** e-Cigarette(s) or vapor product(s) purchased or obtained? Check all that apply:
☐ Recreational dispensary (retail cannabis/marijuana shop) ☐ Vape or smoke shop
☐ Pop-up shop ☐ Grocery store/drugstore/convenience store ☐ Family or friend ☐Dealer
☐ Online Other, describe ______________________________________ ☐ Refuse
If applicable, please provide name(s) and location(s) of stores where you bought the products:

What kind of device(s) were used with this product? Check all that apply:
☐ Disposable e-cigarette or vaping device ☐ E-cigarettes with pre-filled cartridges or refillable cartridges (e.g., using battery pens, Ego, EVO, Ooze pen, Caliplug, 510 battery)
☐ E-cigarette with tank that you refill with liquids (including sub-ohm, mod or modifiable systems)
☐ E-cigarettes with pre-filled or refillable "pods" or pod cartridges (e.g. JUUL, Suorin)
☐ Other, describe ____________________________________

Question	Response
Was this a mod device (a device that allows user to choose higher and/or variable temperatures)?	☐ Yes ☐ No ☐ DK ☐ Refused
Did you modify, or add a substance, to the device(s) that was not intended by the manufacturer? If yes, explain:	☐ Yes ☐ No ☐ DK ☐ Refused
Do you know of anyone else who became ill from vaping nicotine?	☐ Yes ☐ No ☐ DK ☐ Refused
If yes, were nicotine products or devices shared with that person?	☐ Yes ☐ No ☐ DK ☐ Refused
We are working with the CDC and FDA to identify the cause of these lung injuries. Do you still have nicotine vapor products you used prior to developing symptoms that you would be willing to provide to us for testing?	☐ Yes ☐ No ☐ DK ☐ Refused
Do you have any unopened packages of nicotine vapor products that are the same as what you were using prior to developing symptoms?	☐ Yes ☐ No ☐ DK ☐ Refused
Could you take pictures of the nicotine product in the packaging and send them to us. Please take photos of the front and back of the package.	☐ Yes ☐ No ☐ DK ☐ Refused

THC Products	
Any THC e-cigarette or vaping?	☐ Yes ☐ No ☐ DK ☐ Refused
Date last used: ___ / ___ / ___ How frequently were they used? ☐ Daily ☐ Few times/ week ☐ Few times/ month ☐ Monthly or less On average, how many times… per day ___ per week ___ per month ___	
Any use of **flavored** THC in e-Cigarette and/or vapor product(s)?	☐ Yes ☐ No ☐ DK ☐ Refused
How many brands of THC containing products vaped or dabbed in the **past 3 months**?	_____ (whole #) ☐ Refused
What are the brands or names of THC containing products vaped or dabbed in the past 3 months? List as many as can be remembered:	
What was the purpose of THC product(s) use? Was it for…	☐ medical purposes ☐ nonmedical (recreational) purposes ☐ other, specify:_________________
Which THC substance(s) were used in an e-cigarette, vaping device, vaporizer, or dab rig? Check 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 or smoke shop ☐ Pop-up shop ☐ Grocery store/drugstore/convenience store ☐ Family or friend ☐ Illicit dealer ☐ Online ☐ Other, describe ________________________________ ☐ Refuse If applicable, please provide name(s) and location(s) of stores where you bought the products:	
What kind of device(s) were used with this product? Check 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, describe: ________________________	
What kind of THC cartridge(s) were used with device(s)? Check all that apply: ☐ Rove ☐ Dank Vapes ☐ Golden Gorilla ☐ Smart Cart ☐ Other, describe:______________	
Was this a mod device (a device that allows user to choose higher and/or variable temperatures)?	☐ Yes ☐ No ☐ DK ☐ Refused
Did you modify, or add a substance, to the device(s) that was not intended by the manufacturer? If yes, explain:	☐ Yes ☐ No ☐ DK ☐ Refused
Do you know anyone else who became ill from vaping THC?	☐ Yes ☐ No ☐ DK ☐ Refused
If yes, were **nicotine** products or devices shared with that person?	☐ Yes ☐ No ☐ DK ☐ Refused
We are working with the CDC and FDA to identify the cause of these lung injuries. Do you still have any THC vapor products you used prior to developing symptoms that you would be willing to provide to us for testing?	☐ Yes ☐ No ☐ DK ☐ Refused
Do you have any unopened packages of THC vapor products that are the same as what you were using prior to developing symptoms?	☐ Yes ☐ No ☐ DK ☐ Refused
Could you take pictures of the THC product in the packaging and send them to us. Please take photos of the front and back of the package.	☐ Yes ☐ No ☐ DK ☐ Refused

LABORATORY

Nicotine Product Sample(s)			Where sent for testing	Comments
Product / Device description	Sample ID #	Date Collected	FDA, CDC, Private Lab, State Public Health Lab	(e.g., how long in possession, shared, most used etc.)
1.				
2.				
3.				
4.				
5.				

THC Product Sample(s)			Where sent for testing	Comments
Product / Device description	Sample ID #	Date Collected	FDA, CDC, Private Lab, State Public Health Lab	(e.g., how long in possession, shared, most used etc.)
1.				
2.				
3.				
4.				
5.				