



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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory viral panel	If Positive, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	If Positive, specify: <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Not typed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood cultures	If Positive, specify organisms _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legionella urinary antigen	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strep pneumoniae urinary antigen	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mycoplasma pneumoniae	If Positive, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify test _____	If Positive, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other, specify test _____	If Positive, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: _____

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

Required ECMO (Extracorporeal membrane oxygenation)? Supplemental oxygen
If Yes (duration _____)

Clinical specimens

Y	N	Unk	Diagnostic samples gathered	Date of sample	Investigation samples	Specimen ID
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: <input type="checkbox"/> CDC <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Private Lab <input type="checkbox"/> Other PHL:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood sample testing performed? <i>(only include sampling related to the investigation)</i>	____/____/____	Stored at _____ _____ Date sent to WA DOH PHL: ____/____/____	Specimen ID: _____ _____ Tested at: <input type="checkbox"/> CDC <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Private Lab <input type="checkbox"/> Other PHL:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine sample testing performed? <i>(only include sampling related to the investigation)</i>	____/____/____	Stored at _____ _____ Date sent to WA DOH PHL: ____/____/____	Specimen ID: _____ _____ Tested at: <input type="checkbox"/> CDC <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Private Lab <input type="checkbox"/> Other PHL:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: <input type="checkbox"/> CDC <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Private Lab <input type="checkbox"/> Other PHL:

DEATH INFORMATION

Y	N	Unk	Autopsy specimen testing information	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Died?	Death date ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autopsy performed?	Stored at _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autopsy sample collected?	Date collected: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, lipid staining?	Date sent to WA DOH
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, lipid-laden macrophages seen?	PHL:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, findings consistent with acute lung injury?	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If no, specify findings: _____	Tested at:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, other significant autopsy findings: _____	<input type="checkbox"/> CDC <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Private Lab <input type="checkbox"/> Other PHL:
			Location of death: <input type="checkbox"/> At home <input type="checkbox"/> Dead on arrival in emergency department <input type="checkbox"/> Emergency department <input type="checkbox"/> Inpatient <input type="checkbox"/> Unknown <input type="checkbox"/> 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**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

Any combustible tobacco smoking (e.g., cigarettes, cigars)? Yes No DK RefusedAny other tobacco products used (e.g., smokeless tobacco)? Yes No DK RefusedAny combustible marijuana smoking (i.e., any non-vape marijuana)? Yes No DK RefusedAny other marijuana products used (e.g., edibles, tincture)? Yes No DK Refused
Specify: _____**Nicotine Products**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 _____Any use of **flavored** nicotine in e-Cigarette and/or vape product(s)? Yes No DK RefusedHow 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 _____

Was this a mod device (a device that allows user to choose higher and/or variable temperatures)? Yes No DK RefusedDid you modify, or add a substance, to the device(s) that was not intended by the manufacturer? If yes, explain: Yes No DK RefusedDo you know of anyone else who became ill from vaping nicotine? Yes No DK RefusedIf yes, were nicotine products or devices shared with that person? Yes No DK RefusedWe 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 RefusedDo 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 RefusedCould 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
Date last used: ___ / ___ / ___ How frequently were they used? <input type="checkbox"/> Daily <input type="checkbox"/> Few times/ week <input type="checkbox"/> Few times/ month <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
How many brands of THC containing products vaped or dabbed in the past 3 months ?	_____ (whole #) <input type="checkbox"/> 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... <input type="checkbox"/> medical purposes <input type="checkbox"/> nonmedical (recreational) purposes <input type="checkbox"/> other, specify: _____	
Which THC substance(s) were used in an e-cigarette, vaping device, vaporizer, or dab rig? Check all that apply: <input type="checkbox"/> Marijuana herb <input type="checkbox"/> THC oils <input type="checkbox"/> Butane hash oil <input type="checkbox"/> THC concentrate (e.g., wax, batter/budder, crumble, shatter, pull and snap) <input type="checkbox"/> THC powder (e.g., dry sift) <input type="checkbox"/> Other, describe: _____	
Where was the THC e-Cigarette(s) or vaping product(s) purchased or obtained? Check all that apply: <input type="checkbox"/> Medical dispensary <input type="checkbox"/> Recreational dispensary (retail cannabis/marijuana shop) <input type="checkbox"/> Vape or smoke shop <input type="checkbox"/> Pop-up shop <input type="checkbox"/> Grocery store/drugstore/convenience store <input type="checkbox"/> Family or friend <input type="checkbox"/> Illicit dealer <input type="checkbox"/> Online <input type="checkbox"/> Other, describe _____ <input type="checkbox"/> 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: <input type="checkbox"/> Disposable device <input type="checkbox"/> Device with pre-filled cartridges <input type="checkbox"/> Device with tank that you refill with liquids (e.g. mods) <input type="checkbox"/> Device with pre-filled or refillable "pods" or pod cartridges (e.g. JUUL, Suorin) <input type="checkbox"/> Dab rig <input type="checkbox"/> Vaporizer (for dry herbs, etc.) <input type="checkbox"/> Other, describe: _____	
What kind of THC cartridge(s) were used with device(s)? Check all that apply: <input type="checkbox"/> Rove <input type="checkbox"/> Dank Vapes <input type="checkbox"/> Golden Gorilla <input type="checkbox"/> Smart Cart <input type="checkbox"/> Other, describe: _____	
Was this a mod device (a device that allows user to choose higher and/or variable temperatures)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
Did you modify, or add a substance, to the device(s) that was not intended by the manufacturer? If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
Do you know anyone else who became ill from vaping THC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
If yes, were nicotine products or devices shared with that person?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Refused
Do you have any unopened packages of THC vapor products that are the same as what you were using prior to developing symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> 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.				