**Lung Injury Associated with E-cigarette Product Use or Vaping**

**Initial Suspect Case Report Form**

Pennsylvania state and local health departments are investigating cases of unexplained vaping associated severe lung injury. Please complete as much of the information as possible and fax forms to 717-772-6975 or e-mail securely to ra-dhVapingReporting@pa.gov. If the patient is a known Philadelphia resident, please send to the Philadelphia Department of Public Health (fax: 215-238-6947 or email: ACD@phila.gov).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date form complete: | | | | | | | | |
| **Contact Information for Person Filling Out Form** | | | | | | | | |
| Name: | | | | | E-mail: | | | |
| Facility/Organization: | | | | | Phone: | | | |
| Role/title: | | | | |  | | | |
| **Patient Information** | | | | | | | | |
| Full Name: | | | | | Gender: M F | | | |
| Phone Number: | | | | | DOB: | | | |
| Residential Address: | | | | | County of Residence: | | | |
| **Vaping Information** | | | | | | | | |
| Did the patient vape or use e-cigarettes\* in the 3 months (90 days) before symptoms onset?  Yes No Don’t Know  Vaping products available? (e.g., cartridges, pods, tanks)  Yes No Don’t Know  \*Vaping or e-cigarette use includes using an electronic device (e.g., electronic nicotine delivery system (ENDS), electronic cigarette, e-cigarette, vaporizer, vape(s), vape pen, dab pen, or other) or dabbing to inhale substances (e.g., nicotine, marijuana, THC, THC concentrates, CBD, synthetic cannabinoids, flavorings, or other substances). | | | | | | | | |
| **Clinical Information** | | | | | | | | |
| ED? | Yes | | No | Don’t Know | | Date: | |
| Admitted? | Yes | | No | Don’t Know | | Date: | |
| ICU? | Yes | | No | Don’t Know | |  | |
| ECMO? | Yes | | No | Don’t Know | |  | |
| Ventilated? | Yes | | No | Don’t Know | |  | |
| Chest X-ray performed? | Yes | | No | Don’t Know | | Date:  Results: | |
| CT chest performed? | Yes | | No | Don’t Know | | Date:  Results: | |
| Deceased? | Yes | | No | Don’t Know | | Date: | |
| Autopsy performed? | Yes | | No | Don’t Know | |  | |
| Pathology specimens available? (e.g., autopsy, lung biopsy) | Yes | | No | Don’t Know | |  | |
| If known, please list any medical facility where the patient was seen for present illness. | | | | | | | | |
| Facility Type:  ED Outpatient Inpatient  Facility Name: | | Facility Type:  ED Outpatient Inpatient  Facility Name: | | | | | Facility Type:  ED Outpatient Inpatient  Facility Name: | |