**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). If patient is a known Allegheny County resident, please send to the Allegheny Health Department (fax: 412-578-8025).

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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 KnowVaping 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 Admit & Discharged: |
| 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 InpatientFacility Name: | Facility Type:  ED Outpatient InpatientFacility Name: | Facility Type:  ED Outpatient InpatientFacility Name: |