Clinician Report Form - Severe Pulmonary Disease Associated with Vaping

Report Date: _____

Reporter Information:

Name and Title: _____ Phone Number: _____

Facility/Hospital Name: _____

Can medical records be sent to the local health department? ❑ Yes ❑ No

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth (month/day/year): _____/_____/_____ Sex: ❑ Male ❑ Female ❑ Unknown

Patient Address: _____

Primary Phone No.: _____ Secondary Phone No.: _____

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Native Hawaiian/Pacific Islander
❑ American Indian/Alaskan Native ❑ Other: _____
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Pregnancy status: ❑ Pregnant ❑ Not pregnant ❑ Unknown ❑ Not applicable

Patient evaluated at: ❑ ED ❑ Outpatient ❑ Inpatient ❑ Other _____

Date of Admission: _____/_____/_____

Patient current disposition: ❑ Still inpatient
❑ Treated and discharged Date of Discharge: _____/_____/_____
❑ Died Date of Death: _____/_____/_____
❑ Other: _____

Working diagnosis (if still inpatient): _____

Discharge diagnosis (if discharged): _____

Patient Inhalation Use in the Past 90 Days (please ask patient or proxy, if patient is unable to answer):

Any combustible cigarette smoking (nicotine)? ❑ Yes ❑ No ❑ Unknown

Any combustible marijuana use? ❑ Yes ❑ No ❑ Unknown

Any vaping or e-cigarette use reported? ❑ Yes ❑ No ❑ Unknown

Any **THC** e-cigarette use reported? ❑ Yes ❑ No ❑ Unknown
Please list product brands: _____
Devices used for THC: _____
Date of last e-cigarette THC use: _____
Frequency of e-cigarette THC use: _____
Where were products obtained: _____

Any **nicotine** e-cigarette use reported? ❑ Yes ❑ No ❑ Unknown

Please list product brands: _____

Devices used for nicotine: _____

Date of last e-cigarette nicotine use: _____

Frequency of e-cigarette nicotine use: _____

Where were products obtained: _____

Any **kratom** e-cigarette use reported? ❑ Yes ❑ No ❑ Unknown

Please list product brands: _____

Devices used for kratom: _____

Date of last e-cigarette kratom use: _____

Frequency of e-cigarette kratom use: _____

Where were products obtained: _____

Was any product retained and is available for testing? ❑ Yes ❑ No ❑ Unknown

Health and Medical Information:

Date of Illness Onset: _____/_____/_____ Time: ____ : _____

GI symptoms? ❑ Yes ❑ No If yes, please describe: _____

_____

_____

Respiratory symptoms? ❑ Yes ❑ No If yes, please describe: _____

_____

_____

Constitutional symptoms? ❑ Yes ❑ No If yes, please describe: _____

_____

Does that patient have any pre-existing conditions?

Asthma	❑ Yes	❑ No	❑ Unknown
Emphysema/bronchitis (COPD)	❑ Yes	❑ No	❑ Unknown
Bronchiectasis	❑ Yes	❑ No	❑ Unknown
Hypersensitivity pneumonitis	❑ Yes	❑ No	❑ Unknown
Cystic fibrosis	❑ Yes	❑ No	❑ Unknown

Other respiratory? _____

Heart failure	❑ Yes	❑ No	❑ Unknown
History of myocardial infarction	❑ Yes	❑ No	❑ Unknown

Other cardiac? _____

Any rheumatological illness	❑ Yes	❑ No	❑ Unknown
HIV/AIDS	❑ Yes	❑ No	❑ Unknown
Cancer	❑ Yes	❑ No	❑ Unknown

Which type of cancer? _____

Injection drug use	❑ Yes	❑ No	❑ Unknown
Depression	❑ Yes	❑ No	❑ Unknown
Anxiety	❑ Yes	❑ No	❑ Unknown
Other	❑ Yes	❑ No	❑ Unknown

Please specify: _____

Part of Ohio Medical Marijuana program ❑ Yes ❑ No ❑ Unknown

Date of most recent dispense (per OARRS): _____

Which product was dispensed? _____

Testing Information:

Test	Collection Date	Result (pos/neg/pending)	Result Date
Rapid influenza test/PCR			
Respiratory viral panel			
Mycoplasma			
Legionella, urine			
Legionella, PCR			
S. pneumoniae, urine			
Blood culture			
Sputum culture			
Urine culture			
BAL culture			
Other:			

Imaging and Procedures:

Imaging performed:	❑ Chest X-Ray	❑ CT	❑ Both
Infiltrates/opacities present:	❑ Yes	❑ No	
Location of findings:	❑ Bilateral	❑ Left	❑ Right
Impression: *(please copy the Summary/Impression from the CT/CXR radiologist's report or attach a copy of the report)*			

Did the patient have a bronchoscopy? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Results of bronchoscopy: _____

_____

_____

Did the patient have a lung biopsy? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Results of lung biopsy: _____

_____

_____

Treatment:

Was the patient treated with antibiotics? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Antimicrobial name	Route	Dose	Frequency	Date started

Response to antibiotics: ❑ Improvement ❑ No change ❑ Worsening clinical status

Was the patient treated with steroids? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Steroid medication name	Route	Dose	Frequency	Date started

Response to steroids: ❑ Improvement ❑ No change ❑ Worsening clinical status

ICU admission required? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Intubation required? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Ventilatory support (CPAP/BiPAP) required? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Placed on ECMO? ❑ Yes ❑ No ❑ Unknown ❑ Not applicable

Notes:

If you are a provider filling out this form, please contact the local health department in the jurisdiction in which the patient resides to report the suspected case. If patient residence is unknown, report to the local health department in which the provider is located. To locate a local health department please visit: https://odhgateway.odh.ohio.gov/lhdinformationsystem/Directory/GetMyLHD

If you have additional questions, please contact your local health department or Kirtana Ramadugu, ODH epidemiologist, at 614-644-0743 or Courtney Dewart, CDC EIS Officer assigned to ODH, at 614-644-8784.

Local Health Departments – please contact ODH using above contact information for case ID number and link to REDCap data entry form.