



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).

Date form complete:				
Contact Information for Person Filling Out Form				
Name:			E-mail:	
Facility/Organization:			Phone:	
Role/title:				
Patient Information				
Full Name:			Gender: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know				
Vaping products available? (e.g., cartridges, pods, tanks) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Date:
Admitted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Date Admit & Discharged:
ICU?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
ECMO?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Ventilated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Chest X-ray performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Date: Results:
CT chest performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Date: Results:
Deceased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	Date:
Autopsy performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Pathology specimens available? (e.g., autopsy, lung biopsy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
If known, please list any medical facility where the patient was seen for present illness.				
Facility Type: <input type="checkbox"/> ED <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Facility Name:		Facility Type: <input type="checkbox"/> ED <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Facility Name:		Facility Type: <input type="checkbox"/> ED <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Facility Name: