Version 1.3

Pulmonary Disease Associated with E-cigarette Product Use – Preliminary Case Report Form

IDPH and Illinois local health departments are investigating cases of unexplained severe respiratory illness associated with electronic cigarette use (also known as "vaping"/"dabbing") as detailed in CDC's Health Advisory https://emergency.cdc.gov/han/han00421.asp Please complete this form for any suspected case patient and fax to Erika Walzer at: **815-433-1636** or send by secure email to: ewalzer@lasallecounty.org. Thank you.

Date form completed: _____ Name of Hospital: _____
Clinician Name: _____ Clinician Phone Number: _____

Patient Information

Full Name: _____ Gender: ☐ M ☐ F DOB: _____
Phone Number: _____ Email address: _____
MRN: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Race: ☐ White ☐ African-American ☐ Asian/API ☐ Other
Street address: _____ City_____ ZIP_____

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

Any combustible cigarette smoking (nicotine)? ☐ Yes ☐ No (includes cigarettes, cigars, etc.)
Any combustible marijuana? ☐ Yes ☐ No (any non e-cigarette marijuana use)
Any e-cigarette use reported: ☐ Yes ☐ No (vaping, dabbing etc.)

Any **THC** e-cigarette use reported? ☐ Yes ☐ No
If yes, please list product brands: _____
What devices used for THC? _____
Date of last e-cigarette THC use? _____
Frequency of e-cigarette THC use: _____

Any **nicotine** e-cigarette use reported? ☐ Yes ☐ No
If yes, please list brands _____
What devices used for nicotine? _____
Date of last e-cigarette nicotine use _____
Frequency of e-cigarette nicotine use: _____

Any other e-cigarette exposures reported? ☐ Yes ☐ No
If yes, please describe: _____

Used any modified devices or sub-ohm devices*? ☐ Yes ☐ No *(An e-cigarette or vaping device with lower coil resistance)

Please let patient know a local health department or IDPH staff member may try to f/u with patient for additional information.

Patient Clinical Data

Admitted? ☐ Yes ☐ No Date of hospital admission: _____ Date symptoms started:_____

GI symptoms? ☐ Yes ☐ No If yes, describe _____
Respiratory symptoms? ☐ Yes ☐ No If yes, describe _____
Constitutional symptoms? ☐ Yes ☐ No If yes, describe _____

Imaging:

Imaging performed:	CT chest ☐	Chest X-ray ☐	Both ☐
Infiltrates/opacities present:	Yes ☐	No ☐	
Location of findings:	Bilateral ☐	Right ☐	Left ☐
Impression: *(please copy the Summary/Impression from the CT/CXR radiologists report or attach a copy of the report)*			

Infectious Disease Testing:

	+	-	Not Done		+	-	Not Done
Respiratory Viral Panel				Blood cultures			
Influenza				*Strep pneumoniae*			
Legionella				*Mycoplasma pneumoniae*			
Other testing or additional detail:							