

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 Died Other: _____
 Date of Discharge: ____/____/____
 Date of Death: ____/____/____

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Emphysema/bronchitis (COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Bronchiectasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hypersensitivity pneumonitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cystic fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other respiratory? _____			
Heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
History of myocardial infarction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other cardiac? _____			
Any rheumatological illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Which type of cancer? _____			
Injection drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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			
<i>Mycoplasma</i>			
<i>Legionella</i> , urine			
<i>Legionella</i> , PCR			
<i>S. pneumoniae</i> , urine			
Blood culture			
Sputum culture			
Urine culture			
BAL culture			
Other:			

Imaging and Procedures:

Imaging performed:	<input type="checkbox"/> Chest X-Ray	<input type="checkbox"/> CT	<input type="checkbox"/> Both
Infiltrates/opacities present:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Location of findings:	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Impression: <i>(please copy the Summary/Impression from the CT/CXR radiologist's report or attach a copy of the report)</i>			

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.