

## 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.*