Clinician Report Form

Severe Pulmonary Disease Associated with Vaping

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: White

 Black/African American

Telephone Number: (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asian

 Native Hawaiian/Pacific Islander

Telephone Number: (Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ American Indian/Alaskan Native

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Hispanic Non-Hispanic Unknown

Patient evaluated at (please circle): ED visit Treated inpatient Treated outpatient

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient current disposition: Treated and discharged Date of Discharge: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

(please circle) Admitted for inpatient care

 Died Date of Death: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health and Medical Information:**

Date of Illness Onset: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_ : \_\_\_\_\_

Signs/symptoms (circle all that apply):

Shortness of breath Hypoxia Diarrhea Weight Loss

 Cough (with or without blood) Nausea Fever Weakness

 Wheezing Vomiting Chills Dizziness

 Chest Pain (pleuritic) Stomach Pain Palpitation Fatigue

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does that patient have any pre-existing conditions (specifically pulmonary disease due to rheumatologic or neoplastic processes)?

 Yes what condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 No

Was the patient treated for symptoms related Yes No Unknown

to this current pulmonary illness?

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

 Did the patient’s illness respond to antibiotics? Yes No Unknown Not applicable

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

 Did the patient’s illness respond to steroids? Yes No Unknown Not applicable

Did the patient require intubation? Yes No Unknown Not applicable

**Testing Information:**

Was laboratory testing performed? Yes No Unknown

Did any tests indicate that symptoms were indicative of a pulmonary infection? Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| Test | Collection Date | Result (pos/neg/pending) | Result Date |
| Blood cultures |  |  |  |
| Respiratory viral panel |  |  |  |
| Rapid influenza test/PCR |  |  |  |
| Sputum gram stain |  |  |  |
| Respiratory Sync Virus |  |  |  |
| Urine *S. pneumoniae*/*Legionella*/*Mycoplasma* |  |  |  |
| BAL culture |  |  |  |
| Other:  |  |  |  |

Patient’s lowest WBC count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s lowest Platelet count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s highest CRP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s lowest absolute lymphocyte count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s highest AST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s highest ALT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the patient receive a chest x-ray or CT? Yes No Unknown

If yes, which test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Imaging results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Imaging contained any pulmonary infiltrates Yes No Unknown

(opacities or ground glass opacities)?

**Risk Factor Information:**

Did the patient use any vaping, e-cigarette, or marijuana products prior to symptom onset?

 Yes No Unknown

 Which products were used? Marijuana (any kind)

 (circle all that apply) Vaped THC cartridges (e.g. dank vapes)

 Vaped commercial nicotine (e.g. JUUL)

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Product brand and description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How soon after using vaping products did the patient begin experiencing symptoms? (minutes, hours, days)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were the products laced with any other substances prior to use? Yes No Unknown

 If yes, with what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was a nicotine product altered in any way prior to use? Yes No Unknown

 If yes, altered how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does the patient use these vaping products? (circle one)

 Every day

 Some days

 Occasionally

 This was the first time these products were used

 When did the patient start regularly using vaping products (use every day or some days)? (circle one)

 Less than 6 months ago

 Between 6 months and 1 year ago

 More than 1 year ago

Where were the products obtained? From friend or family member

(circle all that apply) From another person that is not a friend or family member

 From store (e.g. gas station, convenience store, vape shop)

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If store, store name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Store address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Store city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Store state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Store ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were the products obtained?

 Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_ : \_\_\_\_\_

Is product available for testing? Yes No Unknown

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.*

**For Local Health Department Use Only**

Health department jurisdiction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date reported to the local health department (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status of investigation: Case status (see OPHCS for case definitions):

🞎 Waiting on medical records 🞎 Confirmed

🞎 Medical records review 🞎 Probable

🞎 Waiting for patient response to interview request 🞎 Suspect

🞎 Patient/proxy refused interview 🞎 Not yet determined

🞎 Patient lost to follow up 🞎 Not a case

🞎 Not a case

🞎 Complete

Case investigator contact information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Local health departments, please return completed forms to the Ohio Department of Health via secure fax at: 614-564-2456, attention: Kirtana Ramadugu or Courtney Dewart.*