Connecticut Department of Public Health
410 Capitol Avenue, MS#11FDS
PO Box 340308
Hartford, CT 06134-0308

DPH Case ID: _____
Date Received: _____

E-cigarette Use or Vaping Product Use Associated Lung Injury Case Report

Fax completed form to Connecticut Department of Public Health confidential fax (860)-509-7910

PATIENT DEMOGRAPHICS

Name (Last, First, MI) _____ MRN _____ DOB _____

Address _____ Phone _____

Gender ☐ Male ☐ Female ☐ Other

Hispanic/Latino? ☐Yes ☐ No

Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐Other _____

HISTORY OF PRESENT ILLNESS

Chief complaint_____ Date symptom(s) started _____

Gastrointestinal symptoms? ☐ Yes ☐ No ☐ Unknown If yes, describe _____

Respiratory symptoms? ☐ Yes ☐ No ☐ Unknown If yes, describe _____

Constitutional symptoms? ☐ Yes ☐ No ☐ Unknown If yes, describe _____
(e.g., fever, chills, malaise)

In your medical opinion, is the patient's current illness due to vaping? ☐ Yes ☐ No
Explain: _____

Were cardiac, neoplastic, and rheumatologic etiologies ruled out? ☐ Yes ☐ No
Explain: _____

PAST MEDICAL HISTORY

Chronic respiratory disease (e.g., asthma, COPD)? ☐ Yes ☐ No If yes, specify_____

Heart disease? ☐ Yes ☐ No If yes, specify_____

Anxiety? ☐ Yes ☐ No

Depression? ☐ Yes ☐ No

Other chronic illness? ☐ Yes ☐ No If yes, specify _____

SUBSTANCE USE IN THE PAST 90 DAYS

Any **nicotine** e-cigarette (vaping) use? ☐ Yes ☐ No Date last used _____

List brands: _____

Any **THC** e-cigarette (vaping) use (including wax, oil or concentrates)? ☐ Yes ☐ No Date last used _____
List brands: _____

Other substances vaped (check all that apply) ☐ CBD ☐ Synthetic cannabinoids ☐ Other, specify _____

IMAGING

CT performed? ☐ Yes ☐ No
Location of abnormal findings ☐ Bilateral ☐ Right ☐ Left ☐ Normal (no findings)
Infiltrates/opacities present? ☐ Yes ☐ No
Subpleural sparing ☐ Yes ☐ No ☐ Unknown

Chest X-ray performed? ☐ Yes ☐ No
Location of abnormal findings ☐ Bilateral ☐ Right ☐ Left ☐ Normal (no findings)
Infiltrates/opacities present ☐ Yes ☐ No

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INFECTIOUS DISEASE AND OTHER TESTING

Respiratory viral panel	☐ Positive (specify _____)	☐ Negative	☐ Pending	☐ Not done
Influenza	☐ Positive (specify _____)	☐ Negative	☐ Pending	☐ Not done
Blood cultures	☐ Positive (specify _____)	☐ Negative	☐ Pending	☐ Not done
Sputum cultures	☐ Positive (specify _____)	☐ Negative	☐ Pending	☐ Not done
Legionella UAT	☐ Positive	☐ Negative	☐ Pending	☐ Not done
Strep pneumoniae UAT	☐ Positive	☐ Negative	☐ Pending	☐ Not done
Mycoplasma pneumoniae	☐ Positive	☐ Negative	☐ Pending	☐ Not done
THC toxicology screen	☐ Positive	☐ Negative	☐ Pending	☐ Not done

CLINICAL COURSE

Admitted to hospital? ☐ Yes ☐ No Admission date _____

Still hospitalized? ☐ Yes ☐ No Discharge date _____

Discharge diagnosis _____

ICU Admission ☐ Yes ☐ No Date admitted to ICU _____

Respiratory Support ☐ Intubated ☐ BiPAP/CPAP/Hi-flow ☐ ECMO

Treated with steroids? ☐ Yes ☐ No If yes, date started _____

Treated with antibiotics? ☐ Yes ☐ No If yes, date started _____

Did patient die? ☐ Yes ☐ No Date of death _____

Autopsy performed? ☐ Yes ☐ No Cause of death: _____

OTHER COMMENTS

PROVIDER/REPORTER INFORMATION

Date form completed _____ Name of Hospital _____

Healthcare provider _____ Healthcare provider phone _____

Person completing report _____ Reporter Phone _____