SEVERE PULMONARY DISEASE ASSOCIATED WITH E-CIGARETTE USE OUTBREAK REPORTING FORM

DEMOGRAPHICS

(MDH USE ONLY)
Case number:

Medical record number: _____ Date of birth: ____/____/____

Patient name: _____

Address: _____

City: _____ State: _____ Phone: _____

If patient is a minor, please include parent information in comments on page 2.

Race (check all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other:

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Sex:

- ☐ Male
- ☐ Female
- ☐ Other

TREATING PROVIDER

Treating provider: _____ Health care facility: _____

Facility location (city, county): _____

Reporter name: _____ Reporter phone: _____

HISTORY OF PRESENT ILLNESS

Admitted? ☐ Yes Date of admission: ____/____/____ ☐ No First recorded SpO2 on room air (pulse oximetry, %): _____

PAST MEDICAL HISTORY

- ☐ Asthma
- ☐ Emphyesema/bronchitis (COPD)
- ☐ Bronchiectasis
- ☐ Hypersensitivity pneumonitis
- ☐ Cystic fibrosis
- ☐ Other chronic lung disease: _____
- ☐ Congestive heart failure
- ☐ History of myocardial infarction
- ☐ Cardiac arrhythmia
- ☐ Depression
- ☐ Anxiety
- ☐ Immunocompromised
- ☐ HIV/AIDS
- ☐ Cancer (type): _____
- ☐ Intravenous drug use
- ☐ Other (specify): _____

SUBSTANCE USE HISTORY

Vaping or e-cigarette use in past 90 days, includes using an electronic device (e.g., electronic nicotine delivery system (ENDS), electronic cigarette, e-cigarette, vaporizer, vape(s), vape pen, or other) or dabbing. ☐ Current ☐ Former ☐ Never ☐ Unknown

Substances vaped (check all that apply):

- ☐ Marijuana, THC, THC concentrates, hash oil, wax
  - ☐ Dank vapes
- ☐ Synthetic cannabinoids (e.g., K2 or Spice)
- ☐ CBD or CBD oil
- ☐ Nicotine
- ☐ Zero-nicotine
- ☐ Other: _____
- ☐ Not documented

IMAGING

Chest X-ray performed? ☐ Yes ☐ No ☐ Unknown
Location of abnormal findings: ☐ Right ☐ Left ☐ Bilateral
Infiltrates/opacitites present? ☐ Yes ☐ No

Chest CT performed? ☐ Yes ☐ No ☐ Unknown
Location of abnormal findings: ☐ Right ☐ Left ☐ Bilateral
Infiltrates/opacities present? ☐ Yes ☐ No
Subpleural sparing? ☐ Yes ☐ No

Please send chest x-ray and CT radiology reports to MDH.

DEPARTMENT OF HEALTH
Minnesota Dept. of Health
PO Box 64975, St. Paul, MN 55164-0975
www.health.state.mn.us

Fax completed form to: 1-800-267-1058
Cases may also be reported by phone: 651-201-5878

INFECTIOUS AND OTHER TESTING

Influenza	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Respiratory viral panel	☐ Positive	☐ Not positive	☐ Pending	☐ Not done

Detail: _____

Pathogen identified: _____

Mycoplasma PCR	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Legionella, urine	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Legionella, PCR	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Streptococcus pneumoniae, urine	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Blastomycosis	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Histoplasmosis	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Pneumocystis pneumonia (PCP)	☐ Positive	☐ Not positive	☐ Pending	☐ Not done
Blood cultures	☐ Positive	☐ Not positive	☐ Pending	☐ Not done

Pathogen identified: _____

Sputum cultures	☐ Positive	☐ Not positive	☐ Pending	☐ Not done

Pathogen identified: _____

Urine cultures	☐ Positive	☐ Not positive	☐ Pending	☐ Not done

Pathogen identified: _____

THC in urine toxicology screen	☐ Positive	☐ Not positive	☐ Pending	☐ Not done

OTHER PROCEDURES AND TREATMENTS

BAL culture done? ☐ Yes ☐ No ☐ Unknown

BAL culture results: ☐ Positive, specify: _____ ☐ Negative ☐ Not done

BAL report general findings: _____

Lung biopsy/other surgical procedure done? ☐ Yes ☐ No ☐ Unknown

Date of lung biopsy/other surgical procedure: _____/_____/_____ *Please send pathology reports to MDH.*

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

Steroids administered? ☐ Yes ☐ No ☐ Unknown If yes, date started: _____/_____/_____

HOSPITAL COURSE

Intensive care unit (ICU) admission ☐ Yes ☐ No ☐ Unknown

Ventilatory support with CPAP or BiPAP (Continuous Positive Airway Pressure or Bilevel Positive Airway Pressure) ☐ Yes ☐ No ☐ Unknown

Mechanical ventilation via endotracheal or tracheal intubation ☐ Yes ☐ No ☐ Unknown

Oxygen via nasal cannula delivery ☐ Yes ☐ No ☐ Unknown

Placed on extracorporeal membrane oxygenation (ECMO) ☐ Yes ☐ No ☐ Unknown

OUTCOMES

Still hospitalized? ☐ Yes ☐ No ☐ Unknown

Discharged? ☐ Yes ☐ No ☐ Unknown Date of discharge or transfer: _____/_____/_____ *Send discharge summary if available.*

Discharge diagnosis (if available): _____

Died? ☐ Yes ☐ No ☐ Unknown Date of death: _____/_____/_____ Autopsy? ☐ Yes ☐ No ☐ Unknown

Other comments: