E-Cigarette or Vaping Product Use Associated Lung Injury (EVALI)
Missouri Case Report Form (CRF)

The Department of Health and Senior Services and local health departments are investigating cases of unexplained lung injury associated with electronic cigarette or vaping product use. Please see the DHSS website for more details about this investigation (https://health.mo.gov/living/wellness/tobacco/lung-injury-outbreak/index.php). Please complete this form for any suspected case patient, encourage the patient to self-complete the ***Patient Survey*** (located on DHSS website: https://health.mo.gov/living/wellness/tobacco/lung-injury-outbreak/pdf/lung-injury-patient-survey.pdf), and **send these to DHSS at *valerie.howard@health.mo.gov* (fax 573-522-2856)**.

Date Form Completed: _____ Name of Hospital: _____
Clinician Name: _____ Clinician Phone Number: _____
Reporter Name: _____ Reporter E-Mail: _____

Patient Demographics

Full Name: _____ Gender ☐ M ☐ F Date of Birth: _____
Phone Number: _____ Race ☐ White ☐ Black ☐ Other Ethnicity ☐ Hispanic ☐ Non-Hispanic
Mailing Address: _____ Zip: _____

Patient Inhalational Use in the Past 90 Days (please ask patient, or proxy if patient unable to answer)

Any combustible *tobacco* use? (i.e. cigarettes, cigars etc.) ☐ Yes ☐ No
Any combustible *marijuana* use? (i.e. any non e-cigarette marijuana) ☐ Yes ☐ No
Any **nicotine** e-cigarette (vaping) use reported? ☐ Yes ☐ No Date last used: _____
If yes, list brands: _____ Frequency: _____ times per day
Any **THC** e-cigarette (vaping) use reported? ☐ Yes ☐ N Date last used: _____
If yes, list brands: _____ Frequency: _____ times per day

Please give the patient a copy of the attached Patient Survey and ask a staff member to assist them if needed.

Patient Symptoms

Chief complaint: _____ Date first symptom started: _____
GI symptoms? ☐ Yes ☐ No If yes, describe: _____
Respiratory symptoms? ☐ Yes ☐ No If yes, describe: _____
Constitutional symptoms? ☐ Yes ☐ No If yes, describe: _____
Weight loss? ☐ Yes ☐ No If yes, amount (lb): _____

Past medical history

Chronic respiratory disease (asthma, COPD etc)? ☐ Yes ☐ No Specify: _____
Depression/anxiety? ☐ Yes ☐ No Specify: _____

Imaging: ***Please attach copy of the radiologist's report for any chest imaging.***

Chest imaging performed	☐ CT chest	☐ Chest X-ray	☐ Both	
Location of abnormal findings	☐ Bilateral	☐ Right	☐ Left	☐ Normal (no findings)
Infiltrates/opacities present	☐ Yes	☐ No		
Subpleural sparing on CT	☐ Yes	☐ No	☐ Unknown	

Infectious Disease Testing

Respiratory viral panel*	☐ Positive	☐ Negative	☐ Pending	☐ Not Done
Influenza	☐ Positive	☐ Negative	☐ Pending	☐ Not Done
Legionella	☐ Positive	☐ Negative	☐ Pending	☐ Not Done
Blood cultures*	☐ Positive	☐ Negative	☐ Pending	☐ Not Done
Strep pneumoniae	☐ Positive	☐ Negative	☐ Pending	☐ Not Done
Mycoplasma pneumoniae	☐ Positive	☐ Negative	☐ Pending	☐ Not Done

*Organism found: _____

Clinical Course

Admitted?	☐ Yes	☐ No	Date admitted/attended: _____
Prior outpatient attendance?	☐ Yes	☐ No	Date of OP attendance: _____
Admitted to ICU (at time of reporting)?	☐ Yes	☐ No	Date admitted to ICU: _____
SIRS criteria met?	☐ Yes	☐ No	
Treated with steroids?	☐ Yes	☐ No	Date of started if known: _____
Required respiratory support?	☐ Intubated	☐ BiPAP/CPAP/High flow	
Deceased (at time of reporting)?	☐ Yes	☐ No	

Clinical Specimens: ***Please contact valerie.howard@health.mo.gov or (573) 522-2824 to coordinate clinical samples to the MO State Public Health Lab.***

Bronchoalveolar lavage performed?	☐ Yes	☐ No	Date of BAL, if known: _____
Lung biopsy performed?	☐ Yes	☐ No	Date of biopsy, if known: _____
Blood sample available for testing?	☐ Yes	☐ No	Date of sample, if known: _____
Urine sample available for testing?	☐ Yes	☐ No	Date of sample, if known: _____

Clinical Impression

In your medical opinion, is the patient's current illness due to vaping? ☐ Yes ☐ No
Were cardiac, neoplastic, and rheumatologic etiologies ruled out? ☐ Yes ☐ No

Final/Working Diagnosis: _____

Please attach a copy of the admission history and physical, discharge summary, if available and patient survey.