New Jersey Department of Health
E-cigarette/Vaping and Lung Injury Investigation Case Report Form

This form is intended for use by local health department staff, poison control center staff, infection preventionists or others who may be reporting a possible case of lung injury related to e-cigarette use or vaping. Please ensure this form is filled out with as much information as possible to aid NJDOH staff in conducting the investigation. Forms should include, at minimum, relevant patient contact information, admission information, infectious disease evaluation and pertinent radiology findings. Completed forms may be sent to NJDOH at CDS.VAPE@doh.nj.gov

Patient Name:

Medical Record Number:

Date of Birth:

Please provide patient contact information:
Patient or Proxy Phone:
Patient Address (include zip code):

Facility Name:

Primary Admission Dx:

Admission Date:

Contact Information for Person Filling Out Form
Name:
Phone and email**:**
Role and Facility:
Main contact to discuss case (include phone or e-mail):

Patient Age:	**Patient Gender:**

Inpatient Admission Information	
Facility Name:	
Was patient admitted to the hospital? ☐ Yes ☐ No	
Was patient admitted to an ICU? ☐ Yes ☐ No If "yes", how many total days in ICU?	
Was the patient first seen in the ED? ☐ Yes ☐ No	
If yes, note Chief Complaint:	
Admitting Provider (if documented): Primary Attending/Medical Team Contact:	
Admit Date:	Admit Unit:
Was this patient seen previously at this facility or another facility for the same issue? ☐ Yes ☐ No ☐ Unknown If Yes, please list:	
Date of Symptom Onset:	
Admit Service:	
Admit Diagnosis:	
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, dab pen, or other) or dabbing to inhale substances (e.g., nicotine, marijuana, THC, THC concentrates, CBD, synthetic cannabinoids, flavorings, or other substances). ☐ Current ☐ Former ☐ Never ☐ Unknown	
If patient has used vaping/e-cigarette in prior 90 days, please list specific products:	
Does the patient have these products available for testing? ☐ Yes ☐ No	
Status of Hospitalization: ☐ Still Inpatient ☐ Discharged Home: Date: ☐ Transfer to other facility: Name: Date: ☐ Deceased: Date: Cause of Death: Autopsy performed? ☐ Yes ☐ No ☐ Unknown	
Discharge Diagnosis:	

Brief Description of Hospital Course:

Relevant Radiology

Chest X-ray	**Chest CT**
Date: Findings:	Date: Findings:

Relevant Infectious Disease (ID) Evaluation

RVP and/or Influenza	Sputum Culture	Other Preliminary Respiratory-related ID (i.e. Legionella UAT, Strep Ag, etc)		
Date:	Date:	Date:	Test:	Result:
Result:	Result:	Date:	Test:	Result:
		Date:	Test:	Result:

General Comments: