Washington State Department of Health

Vaping Associated Illness

DOH Case ID: WA-_ _ _ _ _

COUNTY:

Report Date: ___/___/___

Report status:
- ☐ Initial Report to DOH
- ☐ Information Update
- ☐ Request for assistance
- ☐ Final Report to DOH

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___

Reporter (check all that apply) ☐ Hospital ☐ HCP ☐ Poison Control ☐ Public health agency ☐ ESSENCE ☐ Other _____

Reporter name _____

Reporter phone _____

Reporter agency/organization_____

PATIENT INFORMATION

Name (last, first) _____WA Resident? ☐Yes ☐No

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other _____

Name: _____Phone: _____

Occupation: _____Employer/School _____

Primary language: _____ Interpreter needed? ☐ Yes ☐ No ☐ Unk

OK to talk to case? ☐ Yes ☐ No ☐ Unk

Birth date ___/___/___ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian ☐ Native HI/other PI ☐ Black/Afr Amer ☐ White ☐ Other ☐ Unk

CLINICAL INFORMATION

Was the patient hospitalized at least overnight? ☐Yes ☐No ☐Unk

Admission Date: ___/___/___ **Discharge date** ___/___/___ OR

Symptom onset date: ___/___/____ ☐ Still hospitalized

Hospital name _____

Hospital location _____

Y	N	UNK	
☐	☐	☐	Admitted to intensive care during hospital stay
☐	☐	☐	Required respiratory/ventilator support
☐	☐	☐	Died from illness Death date ___/___/___

EXPOSURE INFORMATION

Does the patient have a history of vaping? ☐Yes ☐No ☐Unk

Date patient last vaped, if known: ___/___/___

How often does patient report vaping? _____

Vaping or e-cigarette use:

Y	N	UNK	
☐	☐	☐	Reports vaping a nicotine containing product?
☐	☐	☐	Reports vaping a THC containing product?
☐	☐	☐	Reports vaping another product?

Other (non-electronic) smoking:

Y	N	UNK	
☐	☐	☐	Current/former tobacco/cigarette smoker?
☐	☐	☐	Current marijuana smoker?

NOTES

INVESTIGATION

Steps completed/ Information attached:

- ☐ Medical records obtained
  - ☐ Medical records attached
- ☐ Medical records abstracted
  - ☐ Abstraction form attached
- ☐ Patient interviewed Date: ___/___/___
  - ☐ Case Questionnaire attached
- ☐ Patient has product or device available for testing
  - ☐ Device collected
  - ☐ Device location: _____
- ☐ Investigation assistance requested:

Fax completed forms to Grant County Health District:

Fax # 509-764-2813

Answers are: Yes, No, Unknown

(Revised 9/10/19)