



Republic of the Philippines  
Department of Health  
**FOOD AND DRUG ADMINISTRATION**



**FDA ADVISORY**  
No. **2019-500**

04 DEC 2019

**TO: HEADS OF HOSPITALS RETAINED BY THE DEPARTMENT OF HEALTH [DOH]**

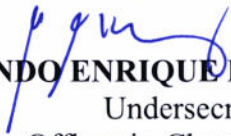
**SUBJECT: Updated contact information for DOH surveillance injuries and illness arising from the use of electronic nicotine and non-nicotine delivery systems (ENDS/ENNDS)**

The Food and Drug Administration (FDA) informs heads of hospitals that all DOH-retained hospitals shall report all probable and confirmed cases of Electronic Cigarette or Vaping Product-Associated Lung Injury (EVALI) to [ecigarettesurveillance@doh.gov.ph](mailto:ecigarettesurveillance@doh.gov.ph).

To capture all the necessary epidemiologic and clinical data, please complete the EVALI case report form enclosed in this advisory.

Private hospitals and public hospitals not retained by the DOH are likewise strongly encouraged to use the same reporting tools to standardize case reporting communication processes.

Dissemination of this advisory to all concerned is hereby requested.

  
**ROLANDO ENRIQUE D. DOMINGO, MD, DPBO**  
Undersecretary of Health  
Officer-in-Charge, Director General





Republic of the Philippines  
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**E-cigarette or Vape-Associated Lung Injury (EVALI) | Case Report Form**

This form must be completed and submitted by all health facilities, Provincial/ Municipal/ City Health Offices and DOH-Centers for Health Development for any probable or confirmed case of EVALI, and send clear scanned copy to [ecigarettesurveillance@doh.gov.ph](mailto:ecigarettesurveillance@doh.gov.ph).

\*Adopted from US – Centers for Disease Control [https://www.cdc.gov/tobacco/basic\\_information/e-cigarettes/severe-lung-disease/healthcare-providers/pdfs/National-Case-Report-Form-v01.pdf](https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease/healthcare-providers/pdfs/National-Case-Report-Form-v01.pdf)

Name of Reporting Health Facility/ PHO/MHO/CHO/ DOH-CHD: \_\_\_\_\_  
Complete Address: \_\_\_\_\_  
Contact No.: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Person completing form: \_\_\_\_\_ Position: \_\_\_\_\_  
Date form completed: \_\_\_\_\_

Case status:  Probable  Confirmed  
Disposition:  Discharged  HAMA  Died (date) \_\_\_\_\_  Others: \_\_\_\_\_

**PART I. PATIENT DEMOGRAPHICS AND EXPOSURES**

**Patient Demographics**

Patient Identification No.: \_\_\_\_\_ Sex: \_\_\_\_\_ Age (years): \_\_\_\_\_  
Region: \_\_\_\_\_ Province: \_\_\_\_\_ Municipality/City: \_\_\_\_\_ Barangay: \_\_\_\_\_

**Patient Substance Use in the past 3 months (90 days)**

Any e-cigarette use or vaping?  Yes  No  
If yes, substance(s) used in the past 3 months (90 days)?  
 Nicotine  Flavors  Illicit drug(s), specify: \_\_\_\_\_  Other substances, specify: \_\_\_\_\_  
 Unknown

What is the frequency of use?  Daily  A few times per week, specify: \_\_\_\_\_  
 A few times per month, specify: \_\_\_\_\_  Monthly or less, how many times per day? \_\_\_\_\_

Combustible tobacco smoking:  Yes  No Other tobacco product (e.g. smokeless tobacco):  Yes  No  
Other illicit drugs, specify: \_\_\_\_\_

What brand(s) of e-liquid were used, name all?

Where was the e-liquid purchased or obtained?  vape shop  pop-up shop  convenience store  family/friend  illicit dealer  online, specify: \_\_\_\_\_  others, specify: \_\_\_\_\_

What kind of device(s) were used, name all?

disposable e-cigarette  e-cigarette with pre-filled cartridges  e-cigarette with refillable tanks  e-cigarette with pre-filled or refillable "pods" or pod cartridges (e.g. JUUL)  Others, specify: \_\_\_\_\_

Was this a mod device (a device that allows user to choose higher and/or variable temperatures)?  Yes  No  Unknown

Did patient modify, or add substance, to the device(s) that were not intended by the manufacturer?  Yes  No  Unknown

If yes, explain: \_\_\_\_\_

Did patient share product with anyone who became ill?  Yes  No



Product sample sent to FDA for testing?  Yes, where and when was sample sent: \_\_\_\_\_   
No

**PART II. CLINICAL INFORMATION**

**Symptoms at initial presentation to medical care**

Chief complaint: \_\_\_\_\_ Date symptom(s) started: \_\_\_\_\_

GI symptoms?  Yes, describe: \_\_\_\_\_

No  Unknown  
Respiratory symptoms?  Yes, describe: \_\_\_\_\_

No  Unknown  
Constitutional symptoms?  Yes, describe: \_\_\_\_\_

No  Unknown  
Weight loss during current illness?  Yes, how many lbs/ kgs were lost? \_\_\_\_\_  No  Unknown

**Medical History**

Chronic respiratory disease (asthma, COPD, etc.)  Yes, specify: \_\_\_\_\_  No

Heart disease  Yes, specify: \_\_\_\_\_  No

Anxiety  Yes  No

Depression  Yes  No

Other chronic illness  Yes, specify: \_\_\_\_\_  No

Pregnant?  Yes, what trimester? \_\_\_\_\_  No  Unknown

**Imaging**

Chest imaging  CXR, result: \_\_\_\_\_

CT, result: \_\_\_\_\_

**Infectious Disease Testing**

Respiratory viral panel done  positive, specify \_\_\_\_\_  negative  pending  not

Influenza done  positive, specify \_\_\_\_\_  negative  pending  not

Blood cultures done  positive, specify \_\_\_\_\_  negative  pending  not

Legionella urinary antigen done  positive  negative  pending  not

Streptococcus pneumonia urinary antigen done  positive  negative  pending  not

Mycoplasma pneumonia done  positive, specify \_\_\_\_\_  negative  pending  not

Others  specify \_\_\_\_\_

**Clinical Course of Lung Injury**

Is this the first time patient is presenting for clinical care for these symptoms?  Yes  No

If yes, is a follow-up visit scheduled?  Yes  No

Was patient hypoxemic at any outpatient, urgent care or Emergency Department visit?  Yes  No

If yes, date(s) \_\_\_\_\_ Lowest value: \_\_\_\_\_

Outpatient visit #1  Yes  No If yes, date of visit \_\_\_\_\_

Outpatient visit #2 [ ] Yes [ ] No  
Were there additional outpatient/clinic visits? [ ] Yes [ ] No  
Urgent care visit #1 [ ] Yes [ ] No  
Urgent care visit #2 [ ] Yes [ ] No  
Were there additional urgent care visits? [ ] Yes [ ] No  
Emergency Department (ED) visit #1 [ ] Yes [ ] No  
ED visit #2 [ ] Yes [ ] No  
Were there additional ED visits? [ ] Yes [ ] No  
Hospitalization #1 [ ] Yes [ ] No

Hospitalization #2 [ ] Yes [ ] No

Were there additional hospitalizations? [ ] Yes [ ] No  
ICU Admission [ ] Yes [ ] No

Treated with steroids?  Yes  No

Treated with antibiotics?  Yes  No

Treated with antivirals?  Yes  No

Required respiratory support?  Intubated (duration \_\_\_\_\_)  BiPAP/CPAP/High flow  
Required ECMO (Extracorporeal membrane oxygenation)?  Yes (duration \_\_\_\_\_)  No

**Clinical specimens**

Bronchoalveolar lavage performed?  Yes, date of sample \_\_\_\_\_  No

If yes, where tested \_\_\_\_\_ Specimen ID \_\_\_\_\_

If yes, lipid staining  Yes  No

If yes, lipid-laden macrophages seen  Yes  No

Blood sample available for testing?  Yes, date of sample \_\_\_\_\_  No

If yes, where tested \_\_\_\_\_ Specimen ID \_\_\_\_\_

Urine sample available for testing?  Yes, date of sample \_\_\_\_\_  No

If yes, where tested \_\_\_\_\_ Specimen ID \_\_\_\_\_

Lung biopsy performed?  Yes, date of sample \_\_\_\_\_  No

If yes, where tested \_\_\_\_\_ Specimen ID \_\_\_\_\_

If yes, lipid staining  Yes  No

If yes, lipid-laden macrophages seen  Yes  No

If yes, findings consistent with acute lung injury?  Yes  No

If no, specify findings \_\_\_\_\_ If yes, other significant findings \_\_\_\_\_

**Death Information**

Died  Yes  No

If yes, specify location \_\_\_\_\_

Date of death \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Contributing causes of death \_\_\_\_\_

Autopsy performed?  Yes  No

If yes, date of visit \_\_\_\_\_

If yes, specify number of additional visits \_\_\_\_\_

If yes, date of visit \_\_\_\_\_

If yes, date of visit \_\_\_\_\_

If yes, specify number of additional visits \_\_\_\_\_

If yes, date of visit \_\_\_\_\_

If yes, date of visit \_\_\_\_\_

If yes, specify number of additional visits \_\_\_\_\_

If yes, hospitalization date \_\_\_\_\_

Discharge date \_\_\_\_\_

If yes, hospitalization date \_\_\_\_\_

Discharge date \_\_\_\_\_

If yes, specify number of additional hospitalizations \_\_\_\_\_

If yes, ICU admission date \_\_\_\_\_

ICU duration (in days) \_\_\_\_\_

If yes, medication: \_\_\_\_\_

dose: \_\_\_\_\_ start date: \_\_\_\_\_

duration: \_\_\_\_\_  Tapered?

If yes, medication: \_\_\_\_\_

dose: \_\_\_\_\_ start date: \_\_\_\_\_

duration: \_\_\_\_\_

If yes, medication: \_\_\_\_\_

dose: \_\_\_\_\_ start date: \_\_\_\_\_

duration: \_\_\_\_\_

If yes, medication: \_\_\_\_\_

dose: \_\_\_\_\_ start date: \_\_\_\_\_

duration: \_\_\_\_\_

If yes, autopsy sample collected  Yes  No

If yes, where tested \_\_\_\_\_ Specimen ID \_\_\_\_\_

If yes, lipid staining performed on autopsy lung tissue  Yes  No

If yes, lipid-laden macrophages seen  Yes  No

If yes, findings consistent with acute lung injury?  Yes  No

If no, specify findings \_\_\_\_\_ If yes, other significant autopsy findings \_\_\_\_\_