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.

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.

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Republic of the Philippines
Department of Health

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.
*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

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	[ ] positive, specify_____	[ ] negative	[ ] pending	[ ] not done
Influenza	[ ] positive, specify_____	[ ] negative	[ ] pending	[ ] not done
Blood cultures	[ ] positive, specify_____	[ ] negative	[ ] pending	[ ] not done
Legionella urinary antigen	[ ] positive	[ ] negative	[ ] pending	[ ] not done
Streptococcus pneumonia urinary antigen	[ ] positive	[ ] negative	[ ] pending	[ ] not done
Mycoplasma pneumonia	[ ] positive, specify_____	[ ] negative	[ ] pending	[ ] not done
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 _____