

*Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number):	
*Resident Name: First: Middle: Last:	
*Gender: F M Other	*Date of Birth: ___/___/___
Sex at Birth: F M Other	Gender Identity (Specify):
*Ethnicity (specify): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown	*Race (specify): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown

EVENT DETAILS
*Event Type: <input type="checkbox"/> Influenza (flu) <input type="checkbox"/> COVID-19 <input type="checkbox"/> Respiratory Syncytial Virus (RSV)
*Date of Event: ___/___/___
*Date of Current Admission to Facility: ___/___/___

Resident Respiratory Pathogens Event Form

*VACCINATION STATUS
Indicate the resident's vaccination status
<input type="checkbox"/> Has the resident received any influenza (flu) vaccine during the current flu season? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Vaccination: ___/___/___
<input type="checkbox"/> Has the resident received any COVID-19 vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of most recent vaccination: ___/___/___
<input type="checkbox"/> Has the resident received a RSV vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Vaccination: ___/___/___
*ANTIVIRAL TREATMENT
Select one. Include treatment that was received/administered in any location (within the facility or an outside facility) for this positive test result.
<input type="checkbox"/> None
Influenza
<input type="checkbox"/> Oseltamivir (Tamiflu)
<input type="checkbox"/> Zanamivir
<input type="checkbox"/> Peramivir
<input type="checkbox"/> Baloxavir
COVID-19
<input type="checkbox"/> Paxlovid
<input type="checkbox"/> Remdesivir
<input type="checkbox"/> Molnupiravir
**Antiviral treatment start date ___/___/___

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)). Public reporting burden of this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666). CDC (form number) Rev v12

*HOSPITALIZATION

*Was the resident hospitalized after this positive test result?

Yes No

**Date of hospitalization __/__/____

*DEATH

*Did the resident die in the 30 days after this positive test result?

Yes No

**Date of death __/__/____