Form Approved
OMB No. 0920-0666
Exp. Date 12/31/2026
www.cdc.gov/nhsn

*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): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to respond ☐ Unknown	*Race (specify): ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined to respond ☐ Unknown

EVENT DETAILS

*Event Type: ☐ Influenza (flu) ☐ COVID-19 ☐ 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

☐ Has the resident received any influenza (flu) vaccine during the current flu season? ☐ Yes ☐ No
If yes, Date of Vaccination: __/__/___

☐ Has the resident received any COVID-19 vaccination? ☐ Yes ☐ No
If yes, Date of most recent vaccination: __/__/___

☐ Has the resident received a RSV vaccine? ☐ Yes ☐ 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.

☐ None

Influenza

☐ Oseltamivir (Tamiflu)

☐ Zanamivir

☐ Peramivir

☐ Baloxavir

COVID-19

☐ Paxlovid

☐ Remdesivir

☐ Molnupiravir

**Antiviral treatment start date __/__/____

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*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 __/__/____