

*Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number):	
*Resident Name: First: Middle: Last:	
*Gender: F M Other	*Date of Birth: ___/___/___
*Ethnicity (specify): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> <b>Declined to respond</b> <input type="checkbox"/> <b>Unknown</b>	*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"/> <b>Declined to respond</b> <input type="checkbox"/> <b>Unknown</b>
*Veteran Resident Type: Veteran Veteran Spouse Gold Star Parent Other (Specify)	

Event Details	
*Event Type: <b>COVID-19</b>	*Date of Current Admission to Facility: ___/___/___
*Date of Event: ___/___/___	

### Resident COVID-19 Event Form

**\*TEST TYPE:** The resident was determined to have a newly positive SARS-CoV-2 viral test result using which of the following testing options (*select only one*):

\_\_\_\_\_ Positive SARS-CoV-2 antigen test **only** [no other testing performed]

\_\_\_\_\_ Positive SARS-CoV-2 NAAT (PCR) **only** [no other testing performed]

\_\_\_\_\_ \*Positive SARS-CoV-2 antigen test **and** negative SARS-CoV-2 NAAT (PCR)

\_\_\_\_\_ \*Any other combination of SARS-CoV-2 NAAT (PCR) and/or antigen test(s) with at least one positive test

± Only select if the two tests were performed **within 2 calendar days from initial test** (test date is calendar day one). Otherwise, select the first test performed only.

**\*RE-INFECTIONS:** Respond to questions based on the **current** COVID-19 event (SARS-COV-2 infection):

\*Is the resident considered to be re-infected with SARS-CoV-2?  Yes  No

\*\*If applicable, was the resident symptomatic at the time of re-infection?  Yes  No

**\*VACCINATION STATUS:** Indicate the vaccination status of the resident on the event date or date of specimen collection.

Has the resident received any COVID-19 vaccine?  Yes  No

Has the resident received an additional or booster dose of vaccine?  Yes  No

**Initial Vaccination:** Select all vaccine doses received, vaccination date, and vaccine manufacturer.

**\*Dose 1** \*\*Vaccination Date: <Drop down menu>

MM/DD/YYYY  
Unknown

**\*\* Manufacturer: <Drop down menu>**

MODERNA - Moderna COVID-19 vaccine  
PFIZBION - Pfizer-BioNTech COVID-19 vaccine  
JANSSEN – Janssen COVID-19 vaccine  
UNSPECIFIED – unspecified vaccine manufacturer

**\*Dose 2** \*\*Vaccination Date: <Drop down menu> **\*\* Manufacturer: <Drop down menu>**

**Additional or Booster Doses:** Indicate the date and manufacturer for the additional or booster doses of vaccine.

**\*\* Additional or Booster Dose** \*\*Vaccination Date: <Drop down menu> **\*\* Manufacturer: <Drop down menu>**

**\*\* Additional or Booster Dose** \*\*Vaccination Date: <Drop down menu> **\*\* Manufacturer: <Drop down menu>**

<p><b>*COVID-19 THERAPY:</b> Indicate if the resident received one of the following therapeutic options for the <b>current</b> COVID-19 event (SARS COV-2 infection):</p> <p><input type="checkbox"/> Did not receive</p> <p><input type="checkbox"/> Casirivimab plus Imdevimab (Regeneron)              Received therapy from stock stored at this facility? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Bamlanivimab plus etesevimab (Lilly)              Received therapy from stock stored at this facility? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Sotrovimab (GlaxoSmithKline)              Received therapy from stock stored at this facility? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	
<p><b>*HOSPITALIZATION:</b> Has the resident been admitted to a hospital or transferred to an acute care facility for this COVID-19 event?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>**Date of hospitalization</b>    /    /    _____</p>	<p><b>*COVID-19 DEATH:</b> Did the resident die from COVID-19 or related complications?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>**Date of death</b>    __ / __ / ____</p>
<p>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)).</p> <p>CDC estimates the average public reporting burden for this collection of information as 40 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1306). CDC 57.159 (Front) October 2021 V12</p>	