OMB No. 0920-1317
Exp. Date: 1/31/2024
www.cdc.gov/nhsn

Resident COVID-19 Event Form

*Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number):	
*Resident Name: Last: First: Middle:	
*Gender: M F Other	*Date of Birth: ___/___/____
*Ethnicity (specify):	*Race (specify):
*Veteran Resident Type: Veteran Veteran Spouse Gold Star Parent Other (Specify)	

Event Details	
*Event Type: **COVID-19**	*Date of Current Admission to Facility: __/__/____
*Date of Event: __/__/____	

***TEST TYPE:** The resident was determined to be SARS-CoV-2 positive using which of the following testing options (ONLY CHOOSE 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

***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 if the resident received a COVID-19 vaccine at **least 14 days** before the newly positive viral test result:

☐ Not vaccinated with COVID-19 vaccine or specimen collected less than 14 days after dose 1

☐ Pfizer-BioNTech COVID-19 vaccine (choose one):

__Dose 1 received at least 14 days before the newly positive viral test result

__Dose 2 received at least 14 days before the newly positive viral test result

☐ Moderna vaccine (choose one):

__Dose 1 received at least 14 days before the newly positive viral test result

__Dose 2 received at least 14 days before the newly positive viral test result

☐ Janssen (Only 1 dose)

☐ Unspecified: Completed COVID-19 vaccination series; unspecified manufacturer

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***COVID-19 THERAPY:** Indicate if the resident received one of the following therapeutic options for the **current** COVID-19 event (SARS COV-2 infection):

☐ Did not receive

☐ Casirivimab plus Imdevimab (Regeneron)

Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Bamlanivimab plus etesevimab (Lilly)

Received therapy from stock stored at this facility? ☐ Yes ☐ No

***HOSPITALIZATION:** Has the resident been admitted to a hospital or transferred to an acute care facility for this COVID-19 event? ☐ Yes ☐ No **Date of hospitalization __/__/____	***COVID-19 DEATH:** Did the resident die from COVID-19 related complications? ☐ Yes ☐ No **Date of death __/__/____