OMB Approved
OMB No. 0920-1317
Exp. Date 01/31/2024
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: ___/___/____
*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**
*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: __/__/____	

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

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

MM/DD/YYYY
Unknown

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>

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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

☐ Sotrovimab (GlaxoSmithKline)

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?	***COVID-19 DEATH:** Did the resident die from COVID-19 or related complications?
☐ Yes ☐ No	☐ Yes ☐ No
**Date of hospitalization __/__/____	**Date of death __/__/____