NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

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
*Is the resident in a State Veterans Home? ☐ Yes ☐ No **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

***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

Which vaccine was received (select all that apply)?

- ☐ Pfizer-BioNTech
- ☐ Moderna
- ☐ Johnson & Johnson's Janssen
- ☐ Unspecified

****PRIMARY SERIES**

Indicate the date(s) for each vaccine received.

****Dose 1** Date: _____ (MM/DD/YYYY)

****Dose 2** Date: _____ (MM/DD/YYYY) ☐ Not received

****ADDITIONAL OR BOOSTER DOSES**

Indicate the date(s) for any additional or booster doses of vaccine.

*Has the resident received any **additional or booster doses** of vaccine? ☐ Yes ☐ No

Date: _____ (MM/DD/YYYY) Date: _____ (MM/DD/YYYY) Date: _____ (MM/DD/YYYY)

***COVID-19 THERAPY**

Indicate if the resident received one of the following therapeutic options for the **current** COVID-19 event (positive SARS CoV-2 viral test result):

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☐ **Did not receive**

☐ Casirivimab/Imdevimab (Regeneron)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Bamlanivimab/etesevimab (Lilly)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Sotrovimab (GlaxoSmithKline)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Evusheld (AstraZeneca)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Paxlovid (Pfizer)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Molnupiravir (Merck)
Received therapy from stock stored at this facility? ☐ Yes ☐ No

☐ Bebtelovimab (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 or related complications?

☐ Yes ☐ No

**Date of death __/__/____

CDC estimates the average public reporting burden for this collection of information as 35 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 July 2022 V15