

*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): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown	*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"/> Declined to respond <input type="checkbox"/> Unknown

<b>EVENT DETAILS</b>
*Event Type: <input type="checkbox"/> Influenza <input type="checkbox"/> COVID-19 <input type="checkbox"/> RSV
*Date of Event: __/__/____
*Date of Current Admission to Facility: __/__/____

## Resident Viral Respiratory Tract Infection (RTI) Event Form

<b>*VACCINATION STATUS</b>
Indicate the resident's vaccination status
<input type="checkbox"/> Has the resident received any influenza (flu) vaccine during the current flu season (2023 – 2024)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Vaccination: __/__/____ <input type="checkbox"/> Date unknown
<input type="checkbox"/> Is the resident up to date with COVID-19 vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of most recent vaccination: __/__/____ <input type="checkbox"/> Date unknown
<input type="checkbox"/> Has the resident received any RSV vaccine during the 2023 – 2024 season (if available) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date of Vaccination: __/__/____ <input type="checkbox"/> Date unknown
<b>*ANTIVIRAL TREATMENT</b>
Select all that apply. Include treatment that was received/administered in any location (within the facility or an outside facility)
<input type="checkbox"/> None
<b>Influenza</b>
<input type="checkbox"/> Oseltamivir (Tamiflu)
<input type="checkbox"/> Zanamivir
<input type="checkbox"/> Peramivir
<input type="checkbox"/> Baloxavir
<b>COVID-19</b>
<input type="checkbox"/> Paxlovid
<input type="checkbox"/> Remdesivir
<input type="checkbox"/> Molnupiravir
**Antiviral treatment start date __/__/____

Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666). CDC (form number) Rev v11.6

**\*HOSPITALIZATION**

\*Has the resident been admitted to a hospital or transferred to an acute care facility within 10 days of this newly positive viral test result?

Yes  No

\*\*Date of hospitalization \_\_/\_\_/\_\_\_\_

**\*DEATH**

\*Did the resident die within 30 days of this newly positive viral test result?

Yes  No

\*\*Date of death \_\_/\_\_/\_\_\_\_