



*Facility ID:	Event #:
*Resident ID:	
Medicare number (or comparable railroad insurance number	er):
*Resident Name: First: Middle:	Last:
*Gender: F M Other	*Date of Birth:/
Sex at Birth: F M Other	Gender Identity (Specify)
*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
EVENT DETAILS	
*Event Type: □ Influenza□ COVID-19 □ RSV	
*Date of Event:/_/	
*Date of Current Admission to Facility:/	
Resident Viral Respiratory Tract Infection (RTI) Event Form	
*VACCINATION STATUS Indicate the resident's vaccination status	
☐ Has the resident received any influenza (flu) vaccine during the current flu season (2023 – 2024)? ☐ Yes ☐ No	
If yes, Date of Vaccination:// □ Date unknown	
\square Is the resident up to date with COVID-19 vaccinations? \square Yes \square No	
If yes, Date of most recent vaccination:/_/ □ Date unknown	
\Box Has the resident received any RSV vaccine during the 2023 – 2024 season (if available) \Box Yes \Box No	
If yes, Date of Vaccination:// □ Date unknown	
*ANTIVIRAL TREATMENT Select all that apply. Include treatment that was received/administered in any location (within the facility or an outside facility)	
☐ None	
Influenza	
Oseltamivir (Tamiflu)	
☐ Zanamivir	
☐ Peramivir	
☐ Baloxavir	
COVID-19	
☐ Paxlovid	
Remdesivir	
☐ Molnupiravir	
**Antiviral treatment start date//	
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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)). Public reporting burden of this collection of information is estimated to average 25 per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data 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, Reports Clearance Officer, 1600





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//