

*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): ☐ 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 (flu) ☐ COVID-19 ☐ Respiratory Syncytial Virus (RSV)
*Date of Event: __/__/__
*Date of Current Admission to Facility: __/__/__

Resident Respiratory Pathogens Event Form

*VACCINATION STATUS
Indicate the resident's vaccination status
☐ Has the resident received any influenza (flu) vaccine during the current flu season? ☐ Yes ☐ No If yes, Date of Vaccination: __/__/__
☐ Has the resident received any COVID-19 vaccination? ☐ Yes ☐ No If yes, Date of most recent vaccination: __/__/__
☐ Has the resident received a RSV vaccine? ☐ Yes ☐ No If yes, Date of Vaccination: __/__/__
*ANTIVIRAL TREATMENT
Select one. Include treatment that was received/administered in any location (within the facility or an outside facility) for this positive test result.
☐ None
Influenza
☐ Oseltamivir (Tamiflu) ☐ Zanamivir ☐ Peramivir ☐ Baloxavir
COVID-19
☐ Paxlovid ☐ Remdesivir ☐ Molnupiravir
**Antiviral treatment start date __/__/__

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 minutes 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 v12

*HOSPITALIZATION

*Was the resident hospitalized after this positive test result?

☐ Yes ☐ No

**Date of hospitalization __/__/____

*DEATH

*Did the resident die in the 30 days after this positive test result?

☐ Yes ☐ No

**Date of death __/__/____