

Resident COVID-19 Event Form

*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): <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
*Is the resident in a State Veterans Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
**Veteran Resident Type: <input type="checkbox"/> Veteran <input type="checkbox"/> Veteran Spouse <input type="checkbox"/> Gold Star Parent <input type="checkbox"/> Other (Specify)	

Event Details

*Event Type: COVID-19	*Date of Current Admission to Facility: ___ / ___ / ___
*Date of Event: ___ / ___ / ___	

***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):

- 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 __/__/____

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)).

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, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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