**Enrollment Questionnaire for Clinics and Shelters**

**Project Name: Canine Leptospirosis Surveillance in Puerto Rico, 2016 – 2017**

This form will provide project coordinators with background information on your facility. Please provide the information as accurately and completely as possible.

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| **GENERAL INFORMATION** |
| Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Facility: ☐ Clinic ☐ Shelter  Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Municipality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Point of Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does your facility have a computer that can be used to record patient test results?: ☐ Yes ☐ No  If a computer is available, what software is available? Check all that apply.  ☐ Microsoft Word ☐ Microsoft Excel ☐ Microsoft Access ☐ Microsoft PowerPoint  Does your facility have a fax machine? ☐ Yes ☐ No  Does your facility have internet access? ☐ Yes ☐ No  Do you vaccinate dogs for leptospirosis? ☐ Yes, name of vaccine(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ No  For clinics, approximately how many dogs does your clinic see? \_\_\_\_\_\_\_\_\_\_\_\_\_ per ☐ week ☐ month  How many dogs with febrile illness of unknown cause does your facility see? \_\_\_\_\_\_\_\_\_\_\_\_ per ☐ week ☐ month  How many dogs diagnosed as or suspected to have leptospirosis does your facility see? \_\_\_\_\_\_\_\_\_ per ☐ week ☐month |
| **QUESTIONS FOR SHELTERS ONLY** |
| **Size and Activity Level:**  Shelter capacity (# of dogs it can house): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average # of new dogs each week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How often is the shelter full? ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never  **Origin of dogs** (provide percentage where appropriate)  Are dogs: ☐ Surrendered by owner: \_\_\_\_ % ☐ Transferred from other facilities: \_\_\_\_ %  ☐ Picked up in the community: \_\_\_\_ % ☐ Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_ %  From which communities do most dogs originate? If possible, specify name of area and an approximate percentage.   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ % 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ % 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ %   What is the most remote distance and community from which you receive animals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Veterinary Care:**  Is veterinary care provided by: ☐ a full-time onsite vet ☐ a part-time onsite vet, how often/week? \_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ a separate veterinary clinic  If a separate veterinary clinic provides care:  Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_  In what capacity does the veterinarian work with your shelter? Check all that apply.  ☐ Euthanasia ☐ Consultation ☐ Spay/neuter ☐ Treatment of sick/injured ☐ Preventive (vaccination, deworming) |
| **Send this form back to the Puerto Rico Health Department by fax to 787-751-6937 or by email to krizia.santos@salud.pr.gov. Thank you!** |