**Respiratory Illness Among People Experiencing Homelessness in Anchorage, Alaska**

**Enrollment form, symptom screening, and vaccination status**

*Complete the Enrollment Consent Form before conducting this survey*.

1. Date and time: \_\_ \_\_/\_\_ \_\_/ \_\_ \_\_ \_\_ \_\_ \_\_\_\_:\_\_\_\_ AM/PM
2. Interviewer name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Site of interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What is your age? \_\_\_\_\_\_\_\_\_ (98-Don’t know; 99-Prefer not to answer)
5. What is your race? (select all that apply)
   1. American Indian or Alaska Native
   2. Asian
   3. Black or African American
   4. Native Hawaiian or Other Pacific Islander
   5. White
6. Prefer not to answer
7. Do you identify as Hispanic? (check one)
   1. Hispanic or Latino
   2. Non-Hispanic or Latino
8. Unknown
9. Prefer not to answer
10. Do you currently describe yourself as male, female, or transgender?
    1. Male
    2. Female
    3. Transgender male
    4. Transgender female
    5. Another gender identity
11. Prefer not to answer
12. What sex were you assigned at birth, on your original birth certificate?
    1. Male
    2. Female
13. Unknown
14. Prefer not to answer
15. Last night, did you sleep? (select one)
    1. In a shelter
    2. Outside (including in a tent or in a car)
    3. In a hotel or motel room
    4. In a private residence with friends or family
    5. In your own private residence
16. In the past two weeks, have you spent at least one night? (select all that apply)
    1. In a shelter
    2. Outside (including in a tent or in a car)
    3. In a hotel or motel room
    4. In a private residence with friends or family
    5. In your own private residence
    6. Incarcerated
17. In the past two weeks, have you been exposed to someone with COVID-19?
    1. Y
    2. N
18. Don’t know
19. In the past one week, have you experienced any of these NEW or WORSENING symptoms? (Select all that apply):
    1. Feeling feverish
    2. Headaches
    3. Cough
    4. Chills or shivering
    5. Sweats
    6. Sore throat or scratchy throat
    7. Runny or stuffy nose
    8. Feeling more tired than usual
    9. Muscle or body aches
    10. Increased trouble with breathing
    11. Ear pain or ear discharge
    12. Diarrhea
    13. Nausea or vomiting
    14. Rash
    15. Loss of smell or taste
    16. None of the above
20. Is there a place that you USUALLY go to when you are sick or need advice about your health?
    1. Y
    2. N
21. Don’t know
22. Have you received COVID vaccination/s?
    1. Y (🡪 Go to 14a)
    2. N (🡪Go to 15)
23. Don’t know (🡪Go to 15)
24. If yes, how many have you received? \_\_\_ (8-Don’t know; 9-Refuse to answer)
25. When did you receive your last COVID vaccine? \_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (approximate date in MM/YYYY)
26. A. Have you received a flu vaccine (flu shot) ?
    1. Y (🡪 Go to 15a)
       1. N (🡪Go to 15B)
27. Don’t know (Go to 15B)

a.  When did you receive your last flu shot? \_\_ \_\_/\_\_ \_\_ \_\_ \_\_ (approximate date in MM/YYYY)

B. Have you received a RSV shot?

1. Y (🡪 Go to 15b)
2. N (🡪 End survey if no respiratory symptoms or collect swabs if respiratory symptoms present)

8. Don’t know (🡪 End survey if no respiratory symptoms or collect swabs if respiratory symptoms present)

b. When did you receive a RSV shot? \_\_ \_\_/\_\_ \_\_ \_\_ \_\_(approximate date in MM/YYYY)

*If any respiratory symptoms are selected, continue to collect swabs.*

**Swab Collection:**

1. Date of collection: \_\_ \_\_ /\_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ (MM/DD/YYYY)
2. Name of individual collecting swab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Specimen collected:
4. Laboratory Result: