Form Approved
OMB Control # 0920-1399
Expiration 05/31/2024

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
   - 9 - Prefer not to answer

6. Do you identify as Hispanic? (check one)
   - 1 - Hispanic or Latino
   - 2 - Non-Hispanic or Latino
   - 8 - Unknown
   - 9 - Prefer not to answer

7. Do you currently describe yourself as male, female, or transgender?
   - 1 - Male
   - 2 - Female
   - 3 - Transgender male
   - 4 - Transgender female
   - 5 - Another gender identity
   - 9 - Prefer not to answer

8. What sex were you assigned at birth, on your original birth certificate?
    1 - Male
    2 - Female
    8 - Unknown
    9 - Prefer not to answer

9. 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

10. 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

11. In the past two weeks, have you been exposed to someone with COVID-19?
    1 - Y
    2 - N
    8 - Don’t know

12. 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

13. Is there a place that you USUALLY go to when you are sick or need advice about your health?
    1 - Y
    2 - N
    8 - Don't know

14. Have you received COVID vaccination/s?
    1 - Y (→ Go to 14a)
    2 - N (→Go to 15)
    8 - Don't know (→Go to 15)

    a. If yes, how many have you received? ___ (8-Don't know; 9-Refuse to answer)
    b. When did you receive your last COVID vaccine? __ __/__ __ __ __ (approximate date in MM/YYYY)

15. A. Have you received a flu vaccine (flu shot) ?
    1 - Y (→ Go to 15a)
    2- N (→Go to 15B)
    8 - 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: