Screening Form

FOR INTERNAL USE ONLY (For Strategy 2b)
Participant identification (ID) number: _____
Name of person completing the form: _____ Community health worker's identification (ID) number: _____
Project Location: ❒$_2$Community-based organization: _____ ❒$_3$Other setting (please specify): _____
Name of partnering organization: _____

Use this chart to record the screening information from each project participant.		
	Pretest Date (MM/DD/YYYY): _____/_____/_____	Posttest Date (MM/DD/YYYY): _____/_____/_____
Blood Pressure Average of two readings: Systolic (top number) Diastolic (bottom number)	 _____mmHg _____mmHg	 _____mmHg _____mmHg
Overweight and Obesity Height Weight Body Mass Index (BMI) Waist measure	 ____ feet ____ inches ____cm ____ pounds / ____ kilograms ____ ____ inches or ___centimeters	 ____ feet ____ inches ____cm ____ pounds / ____ kilograms ____ ____ inches or ___centimeters
Blood Cholesterol Total LDL HDL Triglycerides	 _____mg/dL _____mg/dL _____mg/dL _____mg/dL	 _____mg/dL _____mg/dL _____mg/dL _____mg/dL
Blood Glucose Hb A1C Blood glucose level (nonfasting) Blood glucose level (fasting)	 _____% _____mg/dL _____mg/dL	 _____% _____mg/dL _____mg/dL
All participants with elevated levels are to be referred for further evaluation. Does participant have elevated level(s)? ❒$_1$Yes ❒$_2$No If yes, participant was referred to: _____		
Did the participant go for followup care? ❒$_1$Yes ❒$_2$No		