

# Screening Form

<b>FOR INTERNAL USE ONLY</b> (For Strategy 2b)
Participant identification (ID) number: _____
Name of person completing the form: _____
Promotor(a) identification (ID) number: _____
<b>Project Location:</b> <input type="checkbox"/> <sub>2</sub> Community-based organization: _____ <input type="checkbox"/> <sub>3</sub> 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): ____/____/____
<b>Blood Pressure</b> Average of two readings: Systolic (top number) Diastolic (bottom number)	____ mmHg ____ mmHg	____ mmHg ____ mmHg
<b>Overweight and Obesity</b> Height Weight Body Mass Index (BMI) Waist measure	____ feet ____ inches or ____ meters ____ centimeters ____ pounds or ____ kilograms ____ BMI ____ inches or ____ centimeters	____ feet ____ inches or ____ meters ____ centimeters ____ pounds or ____ kilograms ____ BMI ____ inches or ____ centimeters
<b>Blood Cholesterol</b> Total LDL HDL Triglycerides	____ mg/dL ____ mg/dL ____ mg/dL ____ mg/dL	____ mg/dL ____ mg/dL ____ mg/dL ____ mg/dL
<b>Blood Glucose</b> Hb A1C Blood glucose level (nonfasting) Blood glucose level (fasting)	____ % ____ mg/dL ____ mg/dL	____ % ____ mg/dL ____ mg/dL

<b>All participants with elevated levels are to be referred for further evaluation.</b>
Does participant have elevated level(s)? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
If yes, participant was referred to: _____
Did the participant go for followup care? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No