



Screening Form

FOR INTERNAL USE ONLY

For Strategy 2b

Participant identification (ID) number: _____

Name of person completeing the form: _____

Community health worker identification (ID) number: _____

Location:

₁ Community-based organization: _____

₂ Other setting (please specify): _____

Name of partnering organization: _____



Screening Form (continued)

Use this chart to record the screening information from each participant

Measurement	Pretest Date (MM/DD/YY) ____ / ____ / ____	Posttest Date (MM/DD/YY) ____ / ____ / ____
Blood Pressure (Average of two readings)		
Systolic (top number)	_____ mmHg	_____ mmHg
Diastolic (bottom number)	_____ mmHg	_____ mmHg
Overweight and Obesity		
Height	_____ feet _____ inches	_____ feet _____ inches
Weight	_____ pounds	_____ pounds
BMI	_____ BMI	_____ BMI
Waist measurement	_____ inches	_____ inches
Cholesterol		
Total	_____ mg/dL	_____ mg/dL
LDL	_____ mg/dL	_____ mg/dL
HDL	_____ mg/dL	_____ mg/dL
Triglycerides	_____ mg/dL	_____ mg/dL
Blood Sugar		
A1C	_____ %	_____ %
Blood sugar level (nonfasting)	_____ mg/dL	_____ mg/dL
Blood sugar level (fasting)	_____ mg/dL	_____ mg/dL

Refer all participants with elevated levels for further evaluation.

1. Does participant have elevated level(s)?

- ₁ Yes
- ₂ No

2. Did the participant go for followup care?

- ₁ Yes
- ₂ No

If yes, participant was referred to:
