REPORT AND REFERRAL FORM

INSTRUCTIONS: This form should be completed during the participant’s visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeros where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an “X”. Code the correct entry clearly above the incorrect entry. For “multiple choice” and “Yes/No” type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an “X” and circle the correct response.

A. VISIT 4 CLINIC EXAMINATION

1. Referral/alert made at Visit 4? ........... Yes Y No N
   
   Go to Item 3

2. Was a referral made for:
   a. Blood pressure
      Yes Y No N Not Done U
   b. ECG
      Yes Y No N Not Done U
   c. TIA/stroke in last 6 months
      Yes Y No N Not Done U
   d. Ultrasound
      Yes Y No N Not Done U
   e. Fasting Glucose
      Yes Y No N Not Done U
   f. Oral Glucose Tolerance Test
      Yes Y No N Not Done U
   g. Lipids
      Yes Y No N Not Done U
   h. Other chemistries
      Yes Y No N Not Done U
   i. Other conditions, please specify below.
      Y N U
   j. 

B. ADMINISTRATIVE INFORMATION

3. Date of data collection: .......... [Month] / [Day] / [Year]

   Paper form P

5. Code number of person completing this form: ............... [Blank]

6. Outcome of Ultrasound:
   Normal .................. N
   Abnormal ................ A
   Not Done ................ U
   Delayed ................ D

7. Outcome of ECG review:
   Normal .................. N
   Abnormal but Unchanged .. A
   Changed but Insignificant I
   Abnormal/Significant change S
   Not Done ................ U