

WISEWOMAN Screening Validation Form		Agency:	
Patient Identification		Patient Name: Last First M.I.	
Local Patient or CNDSID:		Date of Birth: ___/___/___	Inactive Date: ___/___/___
Patient Enrollment and Blood Draw			
Screening Date: ___/___/___		Blood Draw Date: ___/___/___	
Data being validated (Range of measures that must be validated):		Validated Measure: (If you are correcting a measurement, please do so in your system and re-batch the corrected record)	
<input type="checkbox"/> Systolic 1 or 2 (<74 mmHg OR >230 mmHg)			
<input type="checkbox"/> Diastolic 1 or 2 (<12 mmHg OR >122 mmHg)			
<input type="checkbox"/> Total Serum Cholesterol (<60 mg/dL OR >400 mg/dL)			
<input type="checkbox"/> HDL (<7 mg/dL OR >155 mg/dL)			
<input type="checkbox"/> LDL (<20 mg/dL OR >344 mg/dL)			
<input type="checkbox"/> Triglycerides (<12 mg/dL OR >1000 mg/dL, fasting) <b>*If Trigly over 400, lab should be repeated as fasting if not on lipid lowering meds or have a history of high cholesterol</b>			
<input type="checkbox"/> Hemoglobin A1C (<4.0 OR > 13.0)			
<input type="checkbox"/> Glucose (<50 mg/dL OR >275 mg/dL)			
<input type="checkbox"/> Height (<58 inches (4ft. 10 inches) OR >74" (6ft. 2 inches))			
<input type="checkbox"/> Weight (<90lbs. OR >350 lbs.)			
<input type="checkbox"/> Physical Activity (<10 minutes OR >1700 minutes) * includes both moderate and vigorous activity			
Signature of Staff Person Validating Measure		Date of Validation	
		___/___/___	
Additional Comments:			
Please fax this form to 919-870-4812, attn. NC WISEWOMAN Data Manager.			

