Finger Stick

FORM CODE: FST
VERSION A 10/07/2005

ID NUMBER: | | | | | | | | CONTACT YEAR | 0 | 6 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

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 zeroes where necessary to fill all boxes. If a paper form is used and 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 number corresponding to the most appropriate response. If a number is circled incorrectly, mark through it with an "X" and circle the correct response.

A. FINGER STICK

1. Do you have any bleeding disorders? ..... Yes 1

No 2

Don't know 7

Refused 8

Missing 9

2. [IF YES, REVIEW SPECIAL PRECAUTIONS AND SPECIFY IN ITEM 2a]

3a. Date of finger stick: | | | / | | | / | | | | |
m m d d y y y y

3b. Time of finger stick: | | | | |
h h m m

4. Number of finger stick attempts: ..... | |

B. GLUCOSE

5. Glucose ..... | | | | mg/dl

C. LIPIDS

6. Cholesterol ..... | | | | mg/dl

7. Triglycerides ..... | | | | mg/dl

8. HDL..... | | | | mg/dl

9. LDL ..... | | | | mg/dl

10. Non HDL ..... | | | | mg/dl

D. ADMINISTRATIVE

11. Method of data collection: ..... Computer 1

Paper form 2

12. Data Collected: .....In Clinic 1

Off Site 2

13. Code number of person completing this form: ..... | | | |