

COMMENTS	<p>- Affix label here-</p> <p>Clinical Center/ID: _____ - _____ - _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Date of ECG: - - (M/D/Y)

2. Performed by: _____

3. Contact type:

₁ Phone

₂ Mail

₃ Visit

₈ Other

4. Visit type:

₁ Screening #

₂ Semi-Annual #

₃ Annual #

₄ Non-Routine

5. Was test completed?

₀ No

₁ Yes

6. Computer reading WHI alert?

₀ No

₁ Yes

7. Physician reading WHI alert?

₀ No

₁ Yes (Specify): _____

8. Was a referral made for follow-up care?

₀ No

₁ Yes →

8.1. Referred by: _____

8.2. Date of referral: - (M/D/Y)

8.3. Referred to:

MD/Clinic: _____

Address: _____

Phone: _____