

Participant's name:

Nurse:

First Visit:

Date:

Start Time (24hrs):
 Finish Time (24hrs):

Place of Assessment:

- 1=Residence (*own home*)
- 2=Medical centre
- 3=Research centre
- 4= Other.....

Participant arrived...

- 1=On their own
(*travelled independently, includes taxi/bus*)
- 2=Arranged transport
(*someone else brought them e.g. drove them*)
- 3=Home visit

Second Visit (only if applicable):

Date:

Start Time (24hrs):
 Finish Time (24hrs):

Place of Assessment:

- 1=Residence (*own home*)
- 2=Medical centre
- 3=Research centre
- 4= Other.....

Participant arrived...

- 1=On their own
(*travelled independently, includes taxi/bus*)
- 2=Arranged transport
(*someone else brought them e.g. drove them*)
- 3=Home visit








TEST	Not done = 0 Done = 1	If test not completed code reason 1 = Participant refused (did not give informed consent) 2 = Unsuitable environment 3 = Participant unable to physically cooperate 4 = Other: (specify) 5 = Test not required	Referral needed (1 = yes)
Height	<input type="checkbox"/>	<input type="checkbox"/>	
Weight	<input type="checkbox"/>	<input type="checkbox"/>	
Bioimpedence	<input type="checkbox"/>	<input type="checkbox"/>	
Vision – distance	<input type="checkbox"/>	<input type="checkbox"/>	
Vision – near	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing screen	<input type="checkbox"/>	<input type="checkbox"/>	
ECG	<input type="checkbox"/>	<input type="checkbox"/>	
Finger pulse oximetry	<input type="checkbox"/>	<input type="checkbox"/>	
BP – lying	<input type="checkbox"/>	<input type="checkbox"/>	
BP – standing	<input type="checkbox"/>	<input type="checkbox"/>	
Waist circumference	<input type="checkbox"/>	<input type="checkbox"/>	
Hip circumference	<input type="checkbox"/>	<input type="checkbox"/>	
Grip strength	<input type="checkbox"/>	<input type="checkbox"/>	

HEIGHT (cm)	Reading 1	Reading 2	Reading 3 (if > .5cm diff)	Calculated height
Standing	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	
Demispan*	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>
Ulna length*	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>

* Measure demispan or ulna length only if standing height cannot be obtained

COMMENTS:

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TANITA INNER SCAN – WEIGHT AND BODY COMPOSITION	Results
Weight	 kg
Total Body Fat (FAT)	 %
Basal Metabolic Rate (BMR)	 kcal
	kJ
Metabolic Age	
Total Body Water (TBW)	 %
Visceral fat rating	
Bone mass	 kg
Muscle mass	 kg

COMMENTS:

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VISION (LUX reading)	Distance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Near <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

VISION (TEST)	Glasses worn (0 = no 1 = yes)		Smallest line read correctly			Number of additional words/letters			Test distance
	normally	for test	R	L	B	R	L	B	
Distance Vision	<input type="checkbox"/>	<input type="checkbox"/>	N	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(m)
Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	N	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(cm)

COMMENTS: (e.g. glasses usually worn but forgot to bring them)

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HEARING	Remove hearing aid for test Normally wears aid (0 = no 1 = yes)	500 Hz	1000 Hz	2000 Hz	4000 Hz
		(0 = does not hear tone 1 = does hear tone)			
Right ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:

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RESTING 12 LEAD ECG

COMMENTS:

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FINGER PULSE OXIMETRY	Reading 1	Reading 2	Reading 3
SPO2 (%)	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Heart rate (bpm)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

COMMENTS:

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BLOOD PRESSURE (mmHg)	Reading 1	Reading 2	Reading 3	Arm used
Lying *	S: <input type="text"/> <input type="text"/> <input type="text"/>	S: <input type="text"/> <input type="text"/> <input type="text"/>	S: <input type="text"/> <input type="text"/> <input type="text"/>	L R
	D: <input type="text"/> <input type="text"/> <input type="text"/>	D: <input type="text"/> <input type="text"/> <input type="text"/>	D: <input type="text"/> <input type="text"/> <input type="text"/>	
Time (24hrs)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*If <u>unable to lie</u> , participant may do the test sitting			Test was done sitting (No = 0 Yes = 1)	<input type="checkbox"/>

Standing *	S: <input type="text"/> <input type="text"/> <input type="text"/>	S: <input type="text"/> <input type="text"/> <input type="text"/>	S: <input type="text"/> <input type="text"/> <input type="text"/>	L R
	D: <input type="text"/> <input type="text"/> <input type="text"/>	D: <input type="text"/> <input type="text"/> <input type="text"/>	D: <input type="text"/> <input type="text"/> <input type="text"/>	
Time (24hrs)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*If <u>unable to stand</u> , participant may do the test sitting			Test was done sitting (No = 0 Yes = 1)	<input type="checkbox"/>

COMMENTS:

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	Reading 1	Reading 2	Reading 3 (if >1cm diff)
WAIST CIRCUMFERENCE (cm)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>
HIP CIRCUMFERENCE (cm)	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>

COMMENTS:

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Grip width (mm)	GRIP STRENGTH	Reading 1	Reading 2	Reading 3
<input type="text"/> <input type="text"/> . <input type="text"/>	Right Hand	<input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="text"/> <input type="text"/> . <input type="text"/> kg
	Left Hand	<input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="text"/> <input type="text"/> . <input type="text"/> kg	<input type="text"/> <input type="text"/> . <input type="text"/> kg
Test conducted standing (1) sitting (0)				<input type="checkbox"/>

COMMENTS:

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