COMMENTS	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

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: _____

K _____ V _____