FORM G: SCREENING VITAL SIGNS

PATIENT ID#: ____ ____ ___	**Center:** _____
PATIENT INITIALS: ____ ____ ___	**Form completed by:** _____
	Date assessment completed: ___ ___/ ___ ___/ ___ ___ ___ ___

Assesment	Value	Comment
1. Weight (kgs)	__ __ __ __	
2. Height (inches)	__ __.__	
3. Temp F^{o}	__ __ __.__	
4. Heart Rate	__ __ __	
5. Blood Pressure	__ __ __/__ __ __	
6. Respiratory Rate	__ __ __	

Tumor Markers	Value (9 = NA)	Comment
7. AFP (alpha-fetal protein level)	_____	
8. b-HCG	_____	
9. CEA	_____	
10. CA-125	_____	
11. PSA	_____	