FORM I: URINALYSIS FORM
Screening

PATIENT ID#: ____ ____ ____

PATIENT INITIALS: ____ ____ ____

Center: ______________________________

Form completed by: ______________________________

Date assessment completed: ___ ___/ ___ ___/ ___ ___ ___ ___

URINALYSIS	A. Value	B. CS?* 1=Yes,Excludes 2=Yes, does not exclude 3=No 9=Not done	C. COMMENTS Provide comments for any clinically significant value.
1. Specific Gravity	☐ ☐ • ☐ ☐ ☐		
2. pH	☐ ☐ • ☐ ☐		
3. Glucose	0☐ neg 1☐trace 2☐present		
4. Protein	0☐ neg 1☐trace 2☐present		
5. Ketones	0☐ absent 1☐trace 2☐present		
6. Occult Blood	0☐ absent 1☐ present† † **If present, evaluate WBC, RBC, and epithelial cells below**:		
7. WBC	0☐ none 1☐few (1-5) 2☐mod (6-10) 3☐heavy (>10)		
8. RBC	0☐ none 1☐few (1-5) 2☐mod (6-10) 3☐heavy (>10)		
9. Epithelial Cells	0☐ none 1☐few (1-5) 2☐mod (6-10) 3☐heavy (>10)		

***Column B**
CS = Clinically significant abnormality