PRESTUDY URINALYSIS FORM

PATIENT ID#: ____ ____ ____

PATIENT INITIALS: ____ ____ ____

VISIT NUMBER (circle 1): **1 4**

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 abnormal 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