

Comments:

- Affix label here-

Clinical Center/ID: ____ - ____ - ____

First Name _____ M.I. _____

Last Name _____

1. Date of Action: ____-____-____ (M/D/Y)

☐₀ No☐₁ Yes

2. Completed 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. What study medication schedule did the participant follow?

HRT ____ pills/week

CEE 0.3 mg ____ pills/week

CEE 0.625 mg ____ pills/week

MPA 2.5 mg ____ pills/week

MPA 5 mg ____ pills/week

MPA 10 mg ____ pills/week

CaD ____ pills/week

6. What is the new study medication schedule?
(Include all study medications the participant should take, including those that you are not changing.)

6.1. Medication:

6.2. Dosage:

1. ____ HRT: ____ pills/week

2. ____ CEE 0.3 mg: ____ pills/week

3. ____ CEE 0.625 mg: ____ pills/week

4. ____ MPA 2.5 mg: ____ pills/week

5. ____ MPA 5 mg: ____ pills/week

6. ____ MPA 10 mg: ____ pills/week

7. ____ CaD: ____ pills/week

6.3 Is this a cyclic regimen?

K _____ V _____

7. Is the new study medication scheduled permanent?

☐₀ No →

☐₁ Yes

7.1. For how long should the participant follow this new study medication schedule?
(Record shortest length of time if more than one medication.)

weeks

8. Why did you make the change in the medication schedule?

8.1. HRT (Mark all that apply.)

☐₁ Bleeding

☐₂ Biopsy abnormality

☐₃ Abnormal transvaginal ultrasound

☐₄ Symptom intolerance

(Specify): _____

☐₈ Other

(Specify): _____

8.2. CaD (Mark all that apply.)

☐₁ Symptom intolerance

(Specify): _____

☐₈ Other

(Specify): _____
