

COMMENTS

- Affix label here-
Clinical Center/ID: _____ - _____ - _____
First Name _____ M.I. _____
Last Name _____

1. Date of Contact: [][]-[][]-[][] (M/D/Y)

2. Completed By: [][][][]

3. Contact Type:

- ₁ Phone
- ₂ Mail
- ₃ Visit
- ₈ Other

4. Visit Type:

- ₁ Screening # [][]
- ₄ Non-Routine

5. Date Washout Started: [][]-[][]-[][] (M/D/Y)

6. Date Washout Reviewed: [][]-[][]-[][] (M/D/Y)

7. Did washout start at least 3 calendar months ago?

No, participant willing to continue. → Stop form and recontact participant when washout is ³ 3 calendar months from washout start date.

₀ No, participant not willing to continue. **HRT ineligible**

₁ Yes

8. "After you went off hormones did you have post-menopausal symptoms such as hot flashes and night sweats?"

₀ No → Schedule SV1

₁ Yes ↓

8.1. "Are you still having symptoms?"

₀ No → Schedule SV1

₁ Yes ↓

8.2. "How severe are the symptoms?"

- ₁ Mild
- ₂ Moderate

8.3. "You may be randomized to a placebo and the symptoms could continue for the rest of the study. Are you interested in participating in the study?"

₀ No **HRT ineligible**

₁ Yes → Schedule SV1

₃ Severe → **HRT ineligible**