**CitAD**

Reference #: _____

**Telephone Contact**
**(TC-1)**

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**Purpose**: Record the information obtained during the telephone contact.

**When**: At T1, T2, T4, and T7, or any unscheduled telephone contacts.

**Completed by**: CitAD certified personnel.

**Information obtained from**: Patient and/or caregiver.

**Instructions**: Items should be answered based on the interviewer's assessment of information provided by the patient and/or caregiver. Any serious adverse events should be recorded on the Safety Report (SR) form.

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### A. Clinic, patient, and visit identification

**1.** Clinic ID: ___ ___ ___ ___

**2.** Patient ID: __C_ ___ ___ ___ ___

**3.** Patient four-letter code: ___ ___ ___ ___

**4.** Date form completed:

___ ___ - ___ ___ - ___ ___
day    month    year

**5.** Visit ID: ___ ___
*Enter "n" for unscheduled contacts.*

**6.** Form revision date:

_1_ _1_ - _a_ _u_ _g_ - _0_ _9_
day    month    year

### B. Medical history

**7.** Is the patient experiencing any side effects:

Yes ( $_1$ )     No ( $_2$ )

*If yes, specify:*

_____
_____
_____
_____
_____

**8.** Current dose *(check only one):*

Not on study drug . . . . . . . . . . . . . . . . . ( $_1$ )
10 mg . . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_2$ )
20 mg . . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_3$ )
30 mg. . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_4$ )

**9.** Does the physician recommend a dose change based on information gathered on this call:

Yes ( $_1$ )     No ( $_2$ )

**10.** Physician recommended dose for the patient until next visit or contact *(check only one):*

Not on study drug . . . . . . . . . . . . . . . . . ( $_1$ )
10 mg . . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_2$ )
20 mg . . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_3$ )
30 mg. . . . . . . . . . . . . . . . . . . . . . . . . . . ( $_4$ )

**11.** Is this a scheduled telephone contact (i.e., T1, T2, T4, or T7):

Yes ( $_1$ )     No ( $_2$ )

**22.** ⌐

**C. Agitation/Aggression subitems on NPI**

**12.** Does the patient have periods when he/she refuses to cooperate or won't let people help him/her? Is he/she hard to handle:

Yes ( 1 )    No ( 2 )

**22.**

**13.** Does the patient get upset with those trying to care for him/her or resist activities such as bathing or changing clothes:

Yes ( 1 )    No ( 2 )

**14.** Is the patient stubborn, having to have things his/her way:

Yes ( 1 )    No ( 2 )

**15.** Is the patient uncooperative, resistive to help from others:

Yes ( 1 )    No ( 2 )

**16.** Does the patient have any other behaviors that make him hard to handle:

Yes ( 1 )    No ( 2 )

**17.** Does the patient shout or curse angrily:

Yes ( 1 )    No ( 2 )

**18.** Does the patient slam doors, kick furniture, or throw things:

Yes ( 1 )    No ( 2 )

**19.** Does the patient attempt to hurt or hit others:

Yes ( 1 )    No ( 2 )

**20.** Does the patient have any other aggressive or agitated behaviors:

Yes ( 1 )    No ( 2 )

*If all items from 14 to 21 are marked "no", re-evaluate the answer in item 13.*

**21.** Determine the frequency and severity of the agitation/aggression:

**a.** Frequency *(check only one):*

Occasionally - less than once per week  ( 1 )
Often - about once per week . . . . . . . . .  ( 2 )
Frequently - several times per week but less than every day . . . . . . . . . .  ( 3 )
Very frequently - once or more per day  ( 4 )

**b.** Severity *(check only one):*

Mild - behavior is disruptive but can be managed with redirection or reassurance . . . . . . . . . . . . . . . . . . . .  ( 1 )
Moderate - behaviors disruptive and difficult to redirect or control . . . . . .  ( 2 )
Marked - agitation is very disruptive and a major source of difficulty; there may be a threat of personal harm. Medications are often required . . . . . . . . . . . . . . . . . . . . .  ( 3 )

**c.** Caregiver distress
How emotionally distressing do you find this behavior *(check only one):*
Not at all . . . . . . . . . . . . . . . . . . . . . . . .  ( 1 )
Minimally . . . . . . . . . . . . . . . . . . . . . . .  ( 2 )
Mildly . . . . . . . . . . . . . . . . . . . . . . . . . .  ( 3 )
Moderately . . . . . . . . . . . . . . . . . . . . . . .  ( 4 )
Severely . . . . . . . . . . . . . . . . . . . . . . . .  ( 5 )
Very severely or extremely . . . . . . . . .  ( 6 )

**D. Respondent**

**22.** Caregiver four-letter code:____ ____ ____ ____

**23.** The information on this form was obtained *(check only one)*:

Exclusively from the patient . . . . . . . . . .  ( 1 )
Primarily from the patient . . . . . . . . . . .  ( 2 )
Equally from the patient and the caregiver . . . . . . . . . . . . . . . . . . . . . . . .  ( 3 )
Primarily from a caregiver . . . . . . . . . .  ( 4 )
Exclusively from a caregiver . . . . . . . .  ( 5 )
Other . . . . . . . . . . . . . . . . . . . . . . . . . . . .  ( 6 )

_____
specify

Patient ID: __C__ ____ ____ ____ ____

### E. Administrative information

*Personnel who conducted telephone contact*

**24.** Date form reviewed by examiner:

____ ____–____ ____–____ ____
day         month       year

**25.** Examiner ID: ____ ____ ____

**26.** Examiner personnel signature:

_____

*Study coordinator review*

**27.** Date form reviewed by study coordinator:

____ ____–____ ____–____ ____
day         month       year

**28.** Study coordinator ID: ____ ____ ____

**29.** Study coordinator signature:

_____