STOP II TRIAL

CHELATION QUESTIONNAIRE FOR STOP II RANDOMIZED PATIENTS

AFFIX PATIENT LABEL HERE

Section A: KEY IDENTIFYING INFORMATION

A1. Person completing form ______________________ (PRINT FULL NAME) ___ ___ ___ (INITIALS)

A2. Date form completed ___ ___ / ___ ___ / ___ ___ ___ ___ (M M D D Y Y Y Y)

Section B: CHELATION PRESCRIPTION INFORMATION

B1. Is patient currently being chelated?

- NO .... 1 — **IF NO, SKIP TO SECTION D**
- YES 2
- UNKNOWN.... -8 — **IF UNKNOWN, SKIP TO SECTION D**

B2. Current prescription for chelation

a. Dose ___ ___ ___ mg/kg/day

b. Frequency ___ days/week

c. Method of delivery

- SUBCUTANEOUS 1
- INTRAVENOUS 2
- INTRAMUSCULAR 3

d. Where administered

- AT HOME 1
- IN CLINIC (OUTPATIENT) 2
- IN HOSPITAL (INPATIENT) 3
- OTHER 9

1. If OTHER, specify

____

____

ML DE

Section C: CURRENT PATIENT COMPLIANCE IN CHELATION PROGRAM

C1. Rate the degree of compliance at this time

HIGH 1
MODERATE 2
POOR................. 3
UNKNOWN........-8

COMPLETE SECTION D ONLY IF THE PATIENT IS NOT BEING CHELATED CURRENTLY OR THE PATIENT'S CURRENT CHELATION STATUS IS UNKNOWN.

Section D: PAST HISTORY OF CHELATION

D1. Did patient ever receive chelation therapy? NO .... 1 YES 2

a. If YES, most recent date discontinued

___ ___ / ___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

Section E: COMMENTS

E1. Do you want to add any additional comments about the patient's current or past chelation treatment? NO .... 1 YES 2

a. If YES, please **PRINT** comments in space provided below:

____

____

____

____

____

FAX COMPLETED FORM TO TAMMI MANSOLF, STOP II DCC, BY FRIDAY, FEBRUARY 21, 2003

617-923-4176