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:
   - ☐ 2 Semi-Annual # ☐☐
   - ☐ 3 Annual # ☐☐
   - ☐ 4 Non-Routine

---

5. **"Do you think you might be interested in the calcium and vitamin D part of the study?"**
   - ☐ 0 No → Ineligible
   - ☐ 1 Yes ↓

   5.1. **"Are you willing to keep any other daily use of vitamin D supplements (besides your study pills) to 600 IU or less?"**
   - ☐ 0 No → Ineligible
   - ☐ 1 Yes → Go to Question 6.

6. **"Are you taking any pills like Prednisone, Decadron, or Medrol? These are known as corticosteroid medications."**
   - ☐ 0 No
   - ☐ 1 Yes → Ineligible

7. **"Are you taking a medication known as calcitriol (Rocaltrol, Calcifex)?"**
   - ☐ 0 No
   - ☐ 1 Yes → Ineligible

8. **"Has a doctor ever told you that you had kidney or bladder stones (renal or urinary calculi)?"**
   - ☐ 0 No
   - ☐ 1 Yes → Ineligible

9. **"Has a doctor ever told you that you have high blood calcium (hypercalcemia)?"**
   - ☐ 0 No
   - ☐ 1 Yes → Ineligible

Staff Code

10. Clinical assessment of expected good health ≤ 3 years: ___ ___ ___
    - ☐ 0 Ineligible
    - ☐ 1 Eligible (based on expected good health)

11. Clinical assessment of dementia: ___ ___ ___
    - ☐ 0 Ineligible
    - ☐ 1 Eligible

12. Staff impression for CaD: ___ ___ ___
    - ☐ 0 Ineligible
    - ☐ 1 Eligible (based on staff impression)

CaD formulation to be dispensed:

___ Chewable ___ Swallowable

Notes:

_____

_____