Does the patient report taking study supplements per protocol (5 pills/day)? **(cmsupp)**

( )1 Yes

1A. Has the patient discontinued taking all study supplements? **(cmdisc)**

( )1 Yes (specify reasons, and continue with question #2)

1. Developed contraindication to omega 3  ( )1 Record on AE Log
2. Physician recommendation **(cmphyrec)** ( )1
3. Patient unable to tolerate side effects **(cmsideeff)** ( )1
4. Other (Specify below) **(cmoth)** ( )1

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(cmots)**

( )0 No (ask question 1B)

1B. Does the patient take some, but less than 5 study supplements per day?

( )1 Yes (specify reasons) (cmless)

a. Physician recommendation **(cmlephy)** ( )1

b. Patient unable to tolerate side effects  **(cmleside)** ( )1

c. Other (Specify below) **(cmleoth)** ( )1

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cmleots)

( )0 No

2. Ask the patient if they have developed any of the following conditions since the last DREAM study visit:

No Yes

Instruct patient to discontinue study supplements.

Record on AE Log and if required, on the CMED log.

a. Atrial Fibrillation **(aeatrial)** 0 1

b. Hemophilia, thrombocytopenia or other bleeding issues

**(aehemop)** 0 1

c. Liver disease **(aeliver)** 0 1

d. Uncontrolled ocular or systemic disease **(mhunoc)** 0 1

e. Started taking an anti-coagulant such as 0 1

Warfarin, Coumadin, Jantoven, Marevan, Uniwarfin,

Heparin or Warf? **(cmantc)**

3. Are there any prescriptions or over-the counter (OTC) medications that have been started, discontinued, or changed since the last DREAM study visit? **(cmotcm)**

**Update the Concomitant Medication Log.**

( )1 Yes

( )0 No

4. Has the patient used antihistamine eye drops since the last study visit? (cmantih)

**Update the Concomitant Medication Log.**

( )1 Yes

( )0 No

5. Is the patient currently taking omega‑3, EPA, DHA, or ALA fatty acids or Vitamin E? Do not include DREAM study supplements **(cmomega)**

**Complete the Dietary Supplement Form.**

( )1 Yes

( )0 No

6. “Since the last DREAM visit or scheduled call, have you had any new symptoms, injuries, illness or side effects or worsening of pre-existing conditions?” **(opworse)**

**Record on the Adverse Event Log.**

( )1 Yes

( )0 No

7. “Since the last DREAM visit or scheduled call, have you have any health event which required major medical intervention or hospitalization?” **(aevst)**

**Record on the Adverse Event Log.**

( )1 Yes

( )0 No

8. Are there any events listed on the adverse event log that were unresolved as of the previous contact? **(aestatus)**

Ask the patient about any unresolved AEs on the Adverse Event Log and update accordingly.

( )1 Yes

( )0 No

9. Return of DREAM bottles and gelcaps

* 1. \_\_\_\_\_ Number of returned supplement bottles **(cmrets)**
  2. \_\_\_\_\_ Number of returned gelcaps **(cmret)**

10. Has the address where the patient should receive study drug changed since their last shipment? **(address)**

Complete a Patient Change of Address Form for IDS and **fax** to the Investigational Drug Service

( )1 Yes

( )0 No

11a. Print last name of staff completing this form**: (qclname)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Certification #: \_\_ \_\_ \_\_ \_\_ **(qcconcert)**

12. Date this form completed **(qccompdtc)**

\_\_\_\_ \_\_\_\_ / \_\_\_\_ \_\_\_\_ / 201 \_\_\_\_

Month Day Year