



Treatment Termination (TT-1)

Purpose: Record information related to termination of study treatment.
When: Treatment with study drug is terminated before week 9 or at end of study.
Completed by: CitAD certified personnel.
Information obtained from: Patient and/or caregiver.
Instructions: Record date of last study treatment and reasons for termination of study treatment. **The data are still collected per protocol if treatment is terminated prior to week 9. Collect study drug as soon as possible.**

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: _____
If not a scheduled visit, use "n" for visit ID.
- 6. Form revision date:
 0 4 f e b 1 0
 day month year

B. Information related to termination

- 7. Date of the treatment termination (*if exact date is not known, provide an estimated date*):

 day month year
- 8. Will study drug be tapered after the date in item 7:
 (Yes) (No)
 (1) (2)

9. Primary reason for treatment termination
(*check only one*):

- End of study (week 9) (1)
- Clinical worsening (2)
- Adverse event/health problem (3)
- Medication conflict (4)
- Uncomfortable side-effects (5)
- Refusal to take study drug (6)
- Family pressure to discontinue (7)
- Patient is unavailable for future follow-up (8)
- Refusal to continue (9)
- Other (10)

_____ specify

10. Other reason(s) for treatment termination
(*check all that apply*):

- a. No other reason (1)
- b. End of study (week 9) (1)
- c. Clinical worsening (1)
- d. Adverse event/health problem (1)
- e. Medication conflict (1)
- f. Uncomfortable side-effects (1)
- g. Refusal to take study drug (1)
- h. Family pressure to discontinue (1)
- i. Patient is unavailable for future follow-up (1)
- j. Refusal to continue (1)
- k. Other (1)

_____ specify

C. Treatment plan

11. How does the study physician plan to treat the patient's agitation after treatment termination (*check all that apply*):

- a. No treatment plan ()
- b. Patient referred to another doctor for treatment ()
- c. Continue or start citalopram ()
- d. Continue or start other drug (*specify*) ()

_____ specify

- e. Continue or start psychotherapy/ counseling ()

- f. Continue or start other services (*specify*) ()

_____ specify

- g. Other ()

_____ specify

D. Administrative information

12. Date form reviewed by study coordinator:

____-____-____
day month year

13. Study coordinator ID: _____

14. Study coordinator signature:
