Collection Calendar

Rhythm™

Your collection schedule is based on the first day of your menstrual cycle (day menstrual blood flow begins). Use this calendar to log the following dates to assist your healthcare provider with interpretation of your results: Enter onset date of **PREVIOUS** menstrual period_____; enter onset date of **CURRENT** menstrual period & all collection dates in the chart below; and onset date of **NEXT** menstrual period _____ *(onset date of menstrual period following the completion of this saliva test)*.

**Note: this calendar is meant to serve as a guide to aid in your collection. See full kit instructions for details on acceptable specimen collection.*

Insert the days of week starting with the first day in which your menstrual cycle began. ie. Tues, Weds, Thurs, etc.

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Do not collect First day of your menstrual cycle Date _____	Date _____	**1st Collection** 7-9 AM Label #1 Date _____	Date _____	**2nd Collection** 7-9 AM Label #2 Date _____	Date _____	Date _____
Day 8	**Day 9**	**Day 10**	**Day 11**	**Day 12**	**Day 13**	**Day 14**
3rd Collection 7-9 AM Label #3 Date _____	Date _____	Date _____	**4th Collection** 7-9 AM Label #4 Date _____	**5th Collection** 7-9 AM Label #5 Date _____	Date _____	**6th Collection** 7-9 AM Label #6 Date _____
Day 15	**Day 16**	**Day 17**	**Day 18**	**Day 19**	**Day 20**	**Day 21**
Date _____	**7th Collection** 7-9 AM Label #7 Date _____	Date _____	**8th Collection** 7-9 AM Label #8 Date _____	Date _____	**9th Collection** 7-9 AM Label #9 Date _____	Date _____
Day 22	**Day 23**	**Day 24**	**Day 25**	**Day 26**	**Day 27**	Unknown
Date _____	**10th Collection** 7-9 AM Label #10 Date _____	Date _____	Date _____	**11th Collection** 7-9 AM Label #11 Date _____	Date _____	**12th Collection** First day of your menstrual cycle Label #12 Date _____

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Collection Schedule

Rhythm™

This form must be completed and returned with your samples

Your collection schedule is based on the first day of your menstrual cycle (the day menstrual blood flow begins). You may find it helpful to use a calendar to remind you of collection dates.

If you are not experiencing periods, you may start on any day, however if you have a recurring menstrual symptom, try to target the test so that the symptom falls on day 11 or 12. The number of samples will help to identify any underlying patterns.

Collect your saliva during the specified time frame each day:	**Day 1**	Count from this day (the first day of your menstrual cycle). **Do not collect on this day.**	
	Day 2	No collection on this day.	
	Days 3, 5, 8, 11, 12, 14, 16, 18, 20, 23, 26	Collect the saliva samples in the morning, and at approximately the same time for each sample.	Use labels #1, 2, 3, 4 etc.
	First day of your NEXT period		Label #12

Please ensure you have read the instructions fully prior to commencing collection of samples.

Key points to remember:

- Avoid alcohol for 12 hours prior to collecting each sample.
- One hour prior to collection do not eat, brush or floss your teeth, use mouthwash, chew gum or use any tobacco products. You may drink ONLY water during this time.
- If you make a mistake or need to restart collecting the samples, please rinse the tube(s) with water only, and allow them to dry naturally.

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Patient details:

First name _____ **Surname** _____ **DOB** ____/____/_____

Note the actual dates of collection below:

Sample 1 Day 3 (First) ___ / ___ / ___	Sample 2 Day 5 ___ / ___ / ___	Sample 3 Day 8 ___ / ___ / ___	Sample 4 Day 11 ___ / ___ / ___
Sample 5 Day 12 ___ / ___ / ___	Sample 6 Day 14 ___ / ___ / ___	Sample 7 Day 16 ___ / ___ / ___	Sample 8 Day 18 ___ / ___ / ___
Sample 9 Day 20 ___ / ___ / ___	Sample 10 Day 23 ___ / ___ / ___	Sample 11 Day 26 ___ / ___ / ___	Sample 12 Day 28 ___ / ___ / ___

Questions

The following questions MUST be completed and returned with your samples.

Please answer ALL the following questions by circling the appropriate response:

- Do you have a regular menstrual cycle? YES NO
- What is your average cycle length? (e.g. 28 days) ___ To ___ Days
- Do you feel you may be entering menopause? YES NO
- Do you experience any symptoms of PMS? YES NO
- Is this test being used for fertility reasons? YES NO

If any hormones or drugs have been/are being taken within 6 months of this test, please indicate below.

Progesterone (Oral or Creams) Last Taken _____

Oestrone / Oestradiol / Oestriol Last Taken _____

Testosterone Last Taken _____

DHEA Last Taken _____

Other (specify) _____ Last Taken _____

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