

Collection Calendar



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	Day 28
Date _____	10th Collection 7-9 AM Label #10 Date _____	Date _____	Date _____	11th Collection 7-9 AM Label #11 Date _____	Date _____	12th Collection 7-9 AM Label #12 Date _____

Day 29 Schedule

Wake up between 6:00AM and 8:00AM and collect five saliva samples according to the following schedule: Date _____	MORNING:	1 hour after rising for the day	(Use label #13)
	MIDDAY:	11:00 AM to 1:00 PM	(Use label #14)
	AFTERNOON:	3:00 PM to 5:00 PM	(Use label #15)
	LATE NIGHT:	10:00 PM to 12:00 AM	(Use label #16)
	EARLY NEXT MORNING: <small>(early morning hours of Day 30)</small>	2:30 AM to 3:30 AM	(Use label #17)



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Collection Schedule



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, 28	Collect the saliva samples in the morning, and at approximately the same time for each sample.	Use labels #1, 2, 3, 4 etc.
	Day 29	Wake between 6 & 8am Morning - 1hr after rising Midday - 11am - 1pm Afternoon - 3pm - 5pm Late Night - 10pm - 12am Early next Morning - 2:30am - 3:30pm	Use labels #13, 14, 15, 16, 17

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 _____