

**Baby hug Follow-up Study (BHFS)  
24 MONTH TRANSCRANIAL (TCD) EXAM**

Form 013  
Revision 1

Tue Sep 22 10:22:53 EDT 2015

<b>Subject: SUBJECT_ID</b>	<b>Letter Code: LETTER_CD</b>	<b>Visit: VISIT_NBR</b>
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**1. Visit Date: VISIT\_DT**

**Part II: EQUIPMENT**

- 1. TCD Examiner's last name
- 2. Patient's position during exam
  - A. SPECIFY

RDR46
PTNTPOS
POS_SP

**Part III: EXAMINATION PERFORMANCE**

- 1. Completeness of exam
  - A. Reason for incomplete exam
    - 1. Specify
  - B. TCD Label

COMPEXAM
INCEXAM
INCEX_SP
TCD_LBL

**Part IV: COORDINATION**

- 1. Checked for completeness and accuracy:
  - A. Certification number:
  - B. Signature
  - C. General Comments

CERT_NO
CERT_SIG
GEN_CMNT