STOP II

ELIGIBILITY QUESTIONNAIRE FOR TCD SCREENING EXAM

(TO DETERMINE ELIGIBILITY FOR TRANSFUSION)

AFFIX PATIENT LABEL HERE

A1. Person completing form (Name): _____ (Initials): | | | |

A2. Date form completed (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

B. PATIENT ID INFORMATION

B1. Has a STOP II Form 01A been completed previously for this patient? ☐ **1. NO** ☐ **2. YES**

↓

GO TO SECTION C

B2. Is the birthdate information on the pre-printed patient label provided by the DCC correct? ☐ **1. NO** ☐ **2. YES**

↓

B2.a If NO, list correct birthdate
___ ___/___ ___/___ ___ ___ ___

B3. Is the gender information on the pre-printed patient label provided by the DCC correct? ☐ **1. NO** ☐ **2. YES**

↓

B3.a If NO, check correct gender:

☐ **1. FEMALE**

☐ **2. MALE**

B4. Race

(READ BOLDED SENTENCES TO PARENT/GUARDIAN OR CHILD IF AGE APPROPRIATE AND SHOW CARD WITH CHOICES)

NIH monitors enrollment of minorities to ensure their adequate representation in all research studies funded by NIH. Please identify the race of the child among the following choices [SHOW CARD]:

☐ **1. Black/African American/not Latin origin** ☐ **2. Black/African American/of Latin Origin**

☐ **3. White/not of Latin origin** ☐ **4. White/of Latin origin**

☐ **5. Asian American/Pacific Islander** ☐ **6. Native American/Alaskan Native**

☐ **7. Other** → B4.a SPECIFY: _____

C. INCLUSION/EXCLUSION CRITERIA

C1. Does the patient have a diagnosis of HbSS or HbS/β^0 thalassemia? ☐ **1. NO** ☐ **2. YES**

C2. Is the patient's age in the range of 2 through 16 years? ☐ **1. NO** ☐ **2. YES**

IF THE ANSWER TO EITHER C1 OR C2 IS NO, THE PATIENT IS NOT ELIGIBLE FOR STUDY.
GO TO SECTION D

C3. Does the patient have a prior history of stroke? ☐ **1. NO** ☐ **2. YES**

C4. Has the patient received a bone marrow transplant? ☐ **1. NO** ☐ **2. YES**

IF THE ANSWER TO EITHER C3 OR C4 IS YES, THE PATIENT IS NOT ELIGIBLE FOR STUDY.
GO TO SECTION D

D. ELIGIBILITY DISPOSITION FOR TCD SCREENING

D1. Is the patient eligible for TCD screening?

☐ **1. NO** → **STOP – FORM COMPLETE**

☐ **2. YES** → **CONTINUE TO QUESTION D2**

D2. Has the patient/patient's parent or legal guardian read and signed the informed consent document for TCD screening?

☐ **1. NO** → D2.a Please specify reason: _____ **STOP – FORM COMPLETE**

☐ **2. YES** → **PROCEED WITH TCD EXAMINATION AND COMPLETE TCD EXAM FORM**

Signature of Study Coordinator:_____ Date: ___ ___/___ ___/___ ___ ___ ___