STOP II TRIAL

TRANSCRANIAL DOPPLER (TCD) EXAMINATION FORM

****AFFIX PATIENT LABEL HERE****

SECTIONS A, B and D TO BE COMPLETED BY STUDY COORDINATOR
SECTION C TO BE COMPLETED BY TCD EXAMINER

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

A2. Date form completed (Month/Day/Year) ____ ____/____ ____/____ ____ ____ ____

B. TCD EXAMINATION INFORMATION

B1. Date of examination (Month/Day/Year): ____ ____/____ ____/____ ____ ____ ____

B2. Reason for examination:

- ☐ **1. Routine TCD Screening Examination to determine eligibility for transfusion**
- ☐ **2. Confirmatory TCD Examination to determine eligibility for transfusion**
- ☐ **3. TCD Screening Examination to determine eligibility for randomization**
- ☐ **4. Confirmatory TCD Screening Examination to determine eligibility for randomization**
- ☐ **5. Entry/Quarterly Visit for potential subject**
- ☐ **6. Quarterly or 6 week Follow-up Visit for trial patient**
- ☐ **7. Neurological Event**

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B2.a Date of Event (Month/Day/Year) ___ ___/___ ___/___ ___ ___ ___

☐ ML ☐ DE

C. TCD EXAMINATION

SECTION C TO BE COMPLETED BY TCD EXAMINER

C1. Name of examiner: _____ (Initials): | | | |

C2. TCD machine serial number: | |

C3. Examiner comments: _____

SECTION D TO BE COMPLETED BY STUDY COORDINATOR

D. CBC INFORMATION (OPTIONAL)

	1. NO	2. YES
D1. Was a sample for hemoglobin/hematocrit drawn at this visit?		

D1.a. Date drawn (Month/Day/Year) ___ ___/___ ___/___ ___ ___ ___

D1.b. Hemoglobin (g/dl) | | . |

D1.c Hematocrit (%) | | . |

ATTACH INSTITUTIONAL REPORT

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