STOP II

TREATMENT DECISION BY PARENT-GUARDIAN OF NEWLY IDENTIFIED CHILD WITH TWO ABNORMAL TCDS OR ONE ABNORMAL TCD WITH TAMM VELOCITY ≥ 220 CM/SEC

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

A1. Person completing form (Name) _____ (Initials): [ ] [ ] [ ]

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

B. TREATMENT DECISION

B1. Did the parent/guardian elect to place child on transfusion for primary stroke prevention?

[ ] **1. NO** →

B1.a Reason:

- [ ] **1. Concerns about transfusion safety**
- [ ] **2. Difficulty participating in program/ anticipated compliance problems**
- [ ] **3. Family/patient not convinced that transfusion is needed**
- [ ] **4. Other:** _____

_____

[ ] **2. YES** →

COMPLETE STOP II ELIGIBILITY QUESTIONNAIRE (FORM 01B)

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