

**STOP II
 TRANSFUSION HISTORY LOG FOR PATIENTS ON TRANSFUSION FOR PRIMARY STROKE PREVENTION
 WHO WERE NOT STOP RANDOMIZED PATIENTS**

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

A1. Person completing log (Name): _____ (Initials):

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

B. TRANSFUSION HISTORY SECTION

B1. Date Transfusion Started (Month/Day/Year): _____/_____/_____

B2. Reason for Transfusions: **1. PRIMARY STROKE PREVENTION**

2. OTHER → B2.a. Specify:

B3. Is Patient Receiving Chelation? **1. NO** **2. YES** → B3.a Date Started _____/_____/_____

B4. Transfusion Visits Since Chronic Transfusion Program Started (List most recent transfusion first):

Pre-transfusion												
a. Date of Transfusion	b. %Hb S	c. Ferritin (ng/ml)	d. Date Blood Drawn	e. OFFICE USE								
1. _____/_____/_____	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							_____/_____/_____	<input type="checkbox"/>
2. _____/_____/_____	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							_____/_____/_____	<input type="checkbox"/>
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5. _____/_____/_____	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							_____/_____/_____	<input type="checkbox"/>
6. _____/_____/_____	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							_____/_____/_____	<input type="checkbox"/>
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B4. Transfusion Visits Since Chronic Transfusion Program Started (continued):

	Pre-transfusion				e. OFFICE USE
	a. Date of Transfusion	b. %Hb S	c. Ferritin (ng/ml)	d. Date Blood Drawn	
9.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
10.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
11.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
12.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
13.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
14.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
15.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
16.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
17.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
18.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
19.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
20.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
21.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
22.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
23.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
24.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
25.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
26.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
27.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
28.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
29.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>
30.	__/__/____	<input type="text"/>	<input type="text"/>	__/__/____	<input type="checkbox"/>

B4. Transfusion Visits Since Chronic Transfusion Program Started (continued):

	Pre-transfusion				e. OFFICE USE
	a. Date of Transfusion	b. %Hb S	c. Ferritin (ng/ml)	d. Date Blood Drawn	
31.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
32.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
33.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
34.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
35.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
36.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
37.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
38.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
39.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
40.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
41.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
42.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
43.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
44.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
45.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
46.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
47.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
48.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
49.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>
50.	___/___/___	<input type="text"/>	<input type="text"/>	___/___/___	<input type="checkbox"/>

Signature of Study Coordinator: _____

Date: ___/___/___