



# Selective Post-Transplant Essential Data

Registry Use Only

Sequence Number:

Date Received:

## Center Identification

CIBMTR Center #

EBMT Code (CIC)

Date of This Report:

Year	Month	Day
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Follow-Up: 1  Day 100 2  6 months 3  annual, specify year:

## Recipient Identification

CIBMTR recipient ID #:

Chronological # of this: HSCT #:

DCI #:

Date of HSCT for this follow-up:

Year	Month	Day
------	-------	-----

Did the recipient receive a subsequent HSCT since the date of contact from the last report? 1  yes 2  no

**Note: "> 100 Days Report" answer since last report**

## New Malignancy, Lymphoproliferative or Myeloproliferative Disorder

### 1. Did a new malignancy, lymphoproliferative or myeloproliferative disorder occur?

Different from the disease for which HSCT performed (not recurrence or transformation).

- 1  yes
- 2  no
- 3  unknown

2. Date of diagnosis:

Year	Month	Day
------	-------	-----

3. Specify:

- 1  Acute myeloid leukemia (AML / ANLL)
- 2  Other leukemia (including ALL) → 4. Specify:
- 3  Breast cancer
- 4  Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
- 5  Clonal cytogenetic abnormality without leukemia or MDS
- 6  Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
- 7  Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
- 8  Hodgkin disease
- 9  Lung cancer
- 10  Lymphoma or lymphoproliferative disease → 5. Is the tumor EBV positive?  
  - 1  yes
  - 2  no
  - 3  unknown
- 11  Melanoma
- 12  Other skin malignancy (basal cell, squamous)
- 13  Myelodysplasia (MDS) / myeloproliferative (MPS) disorder
- 14  Oropharyngeal cancer (tongue, buccal mucosa)
- 15  Sarcoma
- 16  Thyroid cancer
- 17  Other malignancy → 6. Specify:

7. Copy of pathology report / documentation attached?

- 1  yes
- 2  no

**Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.**

CIBMTR Center Number:

CIBMTR Recipient ID:

## Survival

### 8. Survival status at latest follow-up:

1  Alive

9. Latest follow-up:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Year			Month		Day	

2  Dead

10. Date of death:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Year			Month		Day

11. Main **cause of death** (check only one main cause):

- 1  Relapse / Progression / Persistent disease  
2  HSCT related  
causes →

(Check as many as appropriate):

12. 1  yes 2  no GVHD  
13. 1  yes 2  no Cardiac toxicity  
14. 1  yes 2  no Infection  
15. 1  yes 2  no Pulmonary toxicity  
16. 1  yes 2  no Rejection / Poor graft function  
17. 1  yes 2  no VOD  
18. 1  yes 2  no Other →

19. Specify:

3  New malignancy

4  Other

5  Unknown

20. Specify:

3  Lost To Follow-Up (LTF)

21. Last known date alive:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Year			Month		Day

Day of the month is estimated

**Submit Form 2802 — Lost to Follow-Up Declaration**

22. Signed: \_\_\_\_\_

*Person completing form*

Please print name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_