

# ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Initials:

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Today's Date:

		2	0		
Month	Day	Year			

Infusion Date:

		2	0		
Month	Day	Year			

CIBMTR Center Number:

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## Selective Post-Transplant Essential Data

Registry Use Only

Sequence Number:

Date Received:

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### Center Identification

CIBMTR Center #

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EBMT Code (CIC)

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Date of This Report:

Year				Month		Day	

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

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### Recipient Identification

CIBMTR recipient ID #:

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Chronological # of this: HSCT #:

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DCI #:

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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.**

