



Hematopoietic Stem Cell Transplant (HSCT) Infusion

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

OMB No: 0915-0310
Expiration Date: 10/31/2010

CIBMTR Recipient ID:

Donor ID:

NMDP Cord Blood Unit ID: Non-NMDP cord blood unit *

* For non-NMDP cords, see page 11 to report CBU ID and donor demographics.

Today's Date: / /

Month Day Year

Date of HSCT for which this form is being completed: / /

Month Day Year

HSCT type: autologous allogeneic, unrelated allogeneic, related syngeneic (identical twin)

Product type: marrow PBSC cord blood other product, specify: _____
 multiple cord blood units infused

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This form must be completed for all recipients who receive a HSCT product. If more than one type of HSCT product is infused, each product type must be analyzed and reported separately. Questions followed by the symbol indicate additional information necessary to complete the question is referenced in the forms instruction manual; A indicates an appendix.

A series of collections should be considered a single product when they are all from the same donor and use the same collection method and technique (and mobilization, if applicable), even if the collections are performed on different days.

Pre-Collection Therapy

1. Did the donor receive treatment, prior to any stem cell harvest, to enhance the product collection for this HSCT?
(If the HSCT product was from an NMDP donor, or the product is a cord blood unit, then continue with question 20.)

- 1 yes
- 2 no
- 3 NMDP donor

Continue with question 20

- 4 cord blood unit

Continue with question 20

Specify treatment(s): (select all that apply)

2. 1 yes 2 no (autologous only)
Chemotherapy → Report details on disease-specific insert

3. 1 yes 2 no (autologous only)
Anti-CD20 (rituximab, Rituxan) → Report details on disease-specific insert

4. 1 yes 2 no Growth factor(s) → If yes, specify growth factor(s):

5. 1 yes 2 no G-CSF

6. 1 yes 2 no GM-CSF

7. 1 yes 2 no Other → 8. Specify:

9. 1 yes 2 no Other treatment → 10. Specify treatment:

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

CIBMTR Center Number:

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Product Collection

11. Date of product collection: / /
Month Day Year

12. Was more than one collection required for this HSCT?

- 1 yes
- 2 no

13. Specify the number of subsequent days of collection in this episode:

Complete a separate product form for each subsequent collection that was not part of this mobilization.

14. Were anticoagulants added to the product during collection?

- 1 yes
- 2 no

Specify anticoagulant(s):

15. Acid citrate dextrose (ACD)

- 1 yes
- 2 no

16. Citrate phosphate dextrose (CPD)

- 1 yes
- 2 no

17. Heparin

- 1 yes
- 2 no

18. Other anticoagulant

- 1 yes
- 2 no

19. Specify other anticoagulant:

Product Transport and Receipt

20. Was this product collected off-site and shipped to your facility?

- 1 yes
- 2 no

21. Date of receipt of product at your facility: / /
Month Day Year

22. Time of receipt of product (24-hour clock): : standard time
Hour Minute daylight savings time

23. Specify the shipping environment of the product(s):

- 1 frozen gel pack
- 2 frozen cord blood unit(s)
- 3 room temperature per transplant center request
- 4 other temperature

24. Specify shipping environment:

25. (Cord blood product only) Were the secondary containers (e.g., insulated shipping containers and unit cassette) intact when they arrived at your center?

- 1 yes
- 2 no

CIBMTR Center Number:

□ □ □ □ □ □ □ □

CIBMTR Recipient ID:

□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

41. What method was used to thaw the product?

- 1 no wash — thawed at bedside, then infused
- 2 DMSO dilution — thawed in lab (added dextran and albumin), then infused
- 3 washed — thawed in lab (added dextran and albumin), spun and reconstituted in dextran albumin, then infused
- 4 other method →

42. Specify other thaw method: _____

43. Did any adverse events or incidents occur while thawing the product?

- 1 yes
- 2 no

44. Was the product manipulated prior to infusion?

- 1 yes →
- 2 no

If autologous product, continue with question 92; if allogeneic product, continue with question 141.

45. Specify portion manipulated:

- 1 entire product
- 2 portion of product

Specify all methods used to manipulate the product:

46. ABO incompatibility (RBC depletion)

- 1 yes →
- 2 no

Specify method:

- 47. 1 yes 2 no Buffy coat preparation
- 48. 1 yes 2 no Cell separator (i.e., COBE Spectra)
- 49. 1 yes 2 no Density gradient separation (i.e., Ficoll)
- 50. 1 yes 2 no Plasma removal
- 51. 1 yes 2 no Sedimentation (i.e., hetastarch)
- 52. 1 yes 2 no Other →

53. Specify: _____

54. Ex-vivo expansion


- 1 yes
- 2 no

55. Genetic manipulation (gene transfer / transduction)

- 1 yes
- 2 no

56. Volume reduction

- 1 yes
- 2 no

57. CD34+ selection 

- 1 yes →
- 2 no

58. Specify cell selection system used:

- 1 CliniMACS / CliniMax
- 2 Isolex
- 3 other →

59. Specify system: _____

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

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

60. T-cell depletion

- 1 yes →
2 no

Specify method:

61. 1 yes 2 no antibody affinity column →
 62. 1 yes 2 no antibody coated plates →
 63. 1 yes 2 no antibody coated plates and soybean lectin →
 64. 1 yes 2 no antibody + complement →
 65. 1 yes 2 no antibody + toxin →
 66. 1 yes 2 no immunomagnetic beads →
 67. 1 yes 2 no elutriation
 68. 1 yes 2 no CD34 affinity column plus sheep red blood cell rosetting 📖
 69. 1 yes 2 no other →

Report the antibodies used for T-cell depletion at question 73.

70. Specify: _____

71. Other manipulation

- 1 yes →
2 no

72. Specify: _____

73. Were antibodies used during product manipulation?

- 1 yes →
2 no

Specify antibodies:

74. 1 yes 2 no anti CD2
 75. 1 yes 2 no anti CD3
 76. 1 yes 2 no anti CD4
 77. 1 yes 2 no anti CD5
 78. 1 yes 2 no anti CD6
 79. 1 yes 2 no anti CD7
 80. 1 yes 2 no anti CD8
 81. 1 yes 2 no anti CD34
 82. 1 yes 2 no anti TCR alpha / beta (T10-B9)
 83. 1 yes 2 no OKT-3
 84. 1 yes 2 no other CD3 →

85. Specify: _____

86. 1 yes 2 no anti CD52 →

Specify antibodies:
 yes no
 87. 1 2 campath-NOS
 88. 1 2 campath-1G
 89. 1 2 campath-1H

90. 1 yes 2 no other antibody →

91. Specify: _____

Autologous Products Only

The following section refers to autologous products only, including autologous cord blood; if this is not an autologous HSCT, continue with the Product Analysis section at question 141.

92. Were tumor cells detected in the recipient or autologous product prior to HSCT?

- 1 yes
2 no

Specify tumor cell detection method used, and site(s) of tumor cells:

93. Routine histopathology

- 1 yes
2 no

Specify site(s):

94. 1 yes 2 no 3 not tested Circulating blood cells
95. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
96. 1 yes 2 no 3 not tested Collected cells, before purging

97. Polymerase chain reaction (PCR)

- 1 yes
2 no

Specify site(s):

98. 1 yes 2 no 3 not tested Circulating blood cells
99. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
100. 1 yes 2 no 3 not tested Collected cells, before purging

101. Other molecular technique

- 1 yes
2 no

102. Specify method: _____

Specify site(s):

103. 1 yes 2 no 3 not tested Circulating blood cells
104. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
105. 1 yes 2 no 3 not tested Collected cells, before purging

106. Immunohistochemistry

- 1 yes
2 no

Specify site(s):

107. 1 yes 2 no 3 not tested Circulating blood cells
108. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
109. 1 yes 2 no 3 not tested Collected cells, before purging

110. Cell culture technique

- 1 yes
2 no

Specify site(s):

111. 1 yes 2 no 3 not tested Circulating blood cells
112. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
113. 1 yes 2 no 3 not tested Collected cells, before purging

114. Other technique

- 1 yes
2 no

115. Specify method: _____

Specify site(s):

116. 1 yes 2 no 3 not tested Circulating blood cells
117. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
118. 1 yes 2 no 3 not tested Collected cells, before purging

CIBMTR Center Number:

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Product Analysis at 1st Timepoint

Product Analysis at 2nd Timepoint

In this section, report the total number of cells (not cells per kilogram).

	Total Number	Exponent		Total Number	Exponent	
Nucleated cells:	144. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	165. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Mononucleated cells:	145. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	166. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Nucleated red blood cells:	146. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	167. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD34+ cells:	147. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	168. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD3+ cells:	148. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	169. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD4+ cells:	149. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	170. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD8+ cells:	150. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	171. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Viability of cells:	151. <input type="text"/>	%	<input type="checkbox"/> not tested	172. <input type="text"/>	%	<input type="checkbox"/> not tested
Method of testing cell viability:	152. 1 <input type="checkbox"/> 7-AAD 2 <input type="checkbox"/> propidium iodide 3 <input type="checkbox"/> trypan blue 4 <input type="checkbox"/> other method			173. 1 <input type="checkbox"/> 7-AAD 2 <input type="checkbox"/> propidium iodide 3 <input type="checkbox"/> trypan blue 4 <input type="checkbox"/> other method		
Specify other method:	153. _____			174. _____		
Were the colony-forming units (CFU) assessed after thawing? <i>(cord blood product only)</i>	154. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 155 Continue with question 158		175. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 176 Continue with question 179	
Was there growth?	155. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no			176. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no		
Total colonies per product:	156. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown	177. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown
Total CFU-GM:	157. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown	178. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown
Were cultures performed before infusion to test the product(s) for bacterial or fungal infection? <i>(complete for all cell products)</i>	158. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 159 Continue with question 162		179. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 180 Continue with question 183	
Specify results:	159. 1 <input type="checkbox"/> positive 2 <input type="checkbox"/> negative 3 <input type="checkbox"/> unknown			180. 1 <input type="checkbox"/> positive 2 <input type="checkbox"/> negative 3 <input type="checkbox"/> unknown		
Specify organism code(s): <i>(see page 9 for codes)</i>	160. <input type="text"/>	<input type="text"/>	<input type="text"/>	181. <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If code 198, 209, 219, or 259, specify organism:	161. _____			182. _____		

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Codes for Commonly Reported Organisms

Bacterial Infections			Fungal Infections
121 Acinetobacter	139 Fusobacterium	155 Proteus	200 Candida, NOS
122 Actinomyces	144 Haemophilus (all species, including influenzae)	156 Pseudomonas (all species except cepacia & maltophilia)	201 Candida albicans
123 Bacillus	145 Helicobacter pylori	157 Pseudomonas or Burkholderia cepacia	206 Candida guilliermondii
124 Bacteroides (gracillis, uniformis, vulgaris, other species)	146 Klebsiella	158 Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia	202 Candida krusei
125 Bordetella pertussis (whooping cough)	147 Lactobacillus (bulgaricus, acidophilus, other species)	159 Rhodococcus	207 Candida lusitanae
126 Borrelia (Lyme disease)	102 Legionella	107 Rickettsia	203 Candida parapsilosis
127 Branhamella or Moraxella catarrhalis (other species)	103 Leptospira	160 Salmonella (all species)	204 Candida tropicalis
128 Campylobacter (all species)	148 Leptotrichia buccalis	161 Serratia marcescens	205 Candida (Torulopsis) glabrata
129 Capnocytophaga	149 Leuconostoc (all species)	162 Shigella	209 Other Candida, specify ‡
171 Chlamydia pneumoniae	104 Listeria	163 Staphylococcus, coagulase negative (not aureus)	210 Aspergillus, NOS
172 Other chlamydia, specify	150 Methylobacterium	164 Staphylococcus aureus	211 Aspergillus flavus
113 Chlamydia, NOS	151 Micrococcus, NOS	165 Staphylococcus, NOS	212 Aspergillus fumigatus
130 Citrobacter (freundii, other species)	112 Mycobacterium avium–intracellulare (MAC, MAI)	166 Stomatococcus mucilaginosus	213 Aspergillus niger
131 Clostridium (all species except difficile)	174 Mycobacterium species (chelonae, fortuitum, haemophilum, kansasii, mucogenicum)	167 Streptococcus (all species except Enterococcus)	219 Other Aspergillus, specify ‡
132 Clostridium difficile	110 Mycobacterium tuberculosis (tuberculosis, Koch bacillus)	168 Treponema (syphilis)	220 Cryptococcus species
173 Corynebacterium jeikeium	175 Other mycobacterium, specify	169 Vibrio (all species)	230 Fusarium species
133 Corynebacterium (all non-diphtheria species)	176 Mycobacterium, NOS	197 Multiple bacteria at a single site, specify bacterial codes	261 Histoplasmosis
101 Coxiella	105 Mycoplasma	198 Other bacteria, specify ‡	240 Zygomycetes, NOS
134 Enterobacter	152 Neisseria (gonorrhoea, meningitidis, other species)	501 Suspected atypical bacterial infection	241 Mucormycosis
177 Enterococcus, vancomycin resistant (VRE)	106 Nocardia	502 Suspected bacterial infection	242 Rhizopus
135 Enterococcus (all species)	153 Pasteurella multocida		250 Yeast, NOS
136 Escherichia (also E. coli)	154 Propionibacterium (acnes, avidum, granulosum, other species)		259 Other fungus, specify ‡
137 Flavimonas oryzihabitans			260 Pneumocystis (PCP / PJP)
138 Flavobacterium			503 Suspected fungal infection

‡ The codes for “other organism, specify” (codes 198, 209, 219 and 259) should rarely be needed; check with your microbiology lab or HSCT physician before using them.

Product Infusion

183. Was more than one product infused? (e.g., marrow and PBSC, PBSC and cord blood, two different cords, etc.)

- 1 yes
- 2 no

184. Was the product infusion described on this insert intended to produce hematopoietic engraftment?

- 1 yes
- 2 no

185. Date of this product infusion: / /

Month Day Year

186. Time product infusion initiated (24-hour clock): :

- 1 standard time
- 2 daylight savings time

187. Time product infusion completed (24-hour clock): :

- 1 standard time
- 2 daylight savings time

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188. Total volume of product plus additives infused: . mL

189. Specify the route of product infusion:

- 1 intravenous
- 2 intramedullary
- 3 intraperitoneal
- 4 other route of infusion

190. Specify route of infusion:

191. Did the volume of infused product include any added agents?

- 1 yes
- 2 no

Specify agent(s) added:

192. 1 yes 2 no ACD

193. 1 yes 2 no Albumin

194. 1 yes 2 no Antibiotic

195. 1 yes 2 no Dextran

196. 1 yes 2 no Heparin

197. 1 yes 2 no Other

198. Specify agent:

199. Was the entire volume of product infused?

- 1 yes
- 2 no

200. Specify what happened to the reserved portion:

- 1 discarded
- 2 cryopreserved for future use
- 3 other fate

201. Specify:

The following questions refer to all stem cell products except for autologous marrow or autologous PBSC products. If this HSCT used an autologous marrow or autologous PBSC product, continue with question 298.

202. Were there any adverse events or incidents associated with the stem cell infusion?

- 1 yes
- 2 no

Specify the following adverse event(s):		Required Medical Intervention?	Resolved?
Adverse Event			
203. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Brachycardia	204. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	205. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
206. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Chest tightness / pain	207. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	208. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
209. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Chills at time of infusion	210. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	211. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
212. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Fever ≤ 103° F within 24 hours of infusion	213. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	214. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
215. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Fever > 103° F within 24 hours of infusion	216. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	217. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
218. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Gross hemoglobinuria	219. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	220. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
221. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Headache	222. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	223. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
224. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hives	225. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	226. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
227. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypertension	228. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	229. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
230. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypotension	231. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	232. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
233. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypoxia requiring oxygen (O ₂) support	234. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	235. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
236. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Nausea	237. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	238. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
239. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Rigors, mild	240. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	241. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
242. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Rigors, severe	243. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	244. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

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	Adverse Event	Required Medical Intervention?	Resolved?
245.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Shortness of breath (SOB)	246. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	247. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
248.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Tachycardia	249. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	250. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
251.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Vomiting	252. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	253. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
254.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other expected AE		
	255. Specify: _____	256. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	257. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
258.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other unexpected AE		
	259. Specify: _____	260. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	261. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
262.	In the Medical Director's judgement, was the adverse event a direct result of the infusion?		
	1 <input type="checkbox"/> yes		
	2 <input type="checkbox"/> no →		
	263. Specify the most likely cause of the adverse event:		
	1 <input type="checkbox"/> regimen related		
	2 <input type="checkbox"/> product reaction		
	3 <input type="checkbox"/> drug reaction		
	4 <input type="checkbox"/> other illness →		
	264. Specify illness: <input type="text"/>		
	5 <input type="checkbox"/> other reason →		
	265. Specify reason: <input type="text"/>		

Donor Demographic Information

This Donor Demographic Information section (questions 266–287) is to be completed for all stem cell donors except NMDP donors, NMDP cord blood units, and autologous marrow or PBSC donors. If the stem cell product was from an NMDP donor or an autologous marrow or PBSC donor, continue with question 298.

266. Donor's date of birth: date unknown
Month Day Year

267. (Cord blood unit only) Age of mother (approximate): years age unknown

268. (Cord blood unit only) Non-NMDP cord blood unit identification number (CBU ID):

269. (Cord blood unit only) Is the CBU ID number also the ICCBBA ISBT 128 number?
1 yes
2 no

270. (Cord blood unit only) Name of cord blood bank providing CBU: _____

271. Donor's gender:
1 male
2 female →

272. Was the donor ever pregnant?
1 yes →
2 no
3 unknown
4 not applicable, cord blood unit

273. Specify number of pregnancies: unknown

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274. Donor's blood type and Rh factor:

- 1 A positive
- 2 A negative
- 3 B positive
- 4 B negative
- 5 AB positive
- 6 AB negative
- 7 O positive
- 8 O negative
- 9 unknown

275. Did this donor have a central line placed?

- 1 yes →
- 2 no
- 3 not applicable,
cord blood unit
or marrow product

276. Specify the site of the central line placement:

- 1 femoral
- 2 subclavian
- 3 internal jugular
- 4 other site →

277. Specify site:

278. Donor's ethnicity:

- 1 Hispanic or Latino
- 2 not Hispanic nor Latino
- 3 unknown

279. Donor's race: (Mark the group(s) in which the donor is a member. Check all that apply.) A

White

- 1 Eastern European
- 2 Mediterranean
- 3 Middle Eastern
- 4 North Coast of Africa
- 5 North American
- 6 Northern European
- 7 Western European
- 8 White Caribbean
- 9 White South or
Central American
- 10 Other White

Black or African American

- 11 African (both parents
born in Africa)
- 12 African American
- 13 Black Caribbean
- 14 Black South or
Central American

**American Indian or
Alaska Native**

- 15 Alaskan Native or
Aleut
- 16 North American
Indian

- 17 American Indian,
South or Central
America
- 18 Caribbean Indian

Asian

- 19 South Asian
- 20 Filipino (Pilipino)
- 21 Japanese
- 22 Korean
- 23 Chinese
- 24 Vietnamese
- 25 Other Southeast
Asian

**Native Hawaiian or Other
Pacific Islander**

- 26 Guamanian
- 27 Hawaiian
- 28 Samoan
- 29 Other Pacific Islander

Decline

- 30 Donor declines to
provide race
- 31 Donor's race
unknown

280. What is the relationship of the donor to the recipient?

- 1 sibling
- 2 recipient's child
- 3 other relative →
- 4 unrelated

281. Specify the relationship of the donor to the recipient:

- 1 parent
- 2 aunt
- 3 uncle
- 4 cousin
- 5 other

relative → 282. Specify relationship:

CIBMTR Center Number:

CIBMTR Recipient ID:

283. Was the donor / product tested for potentially transplantable genetic diseases?

- 1 yes
- 2 no
- 3 unknown

Specify disease(s) tested:

284. 1 yes 2 no Sickle cell anemia

285. 1 yes 2 no Thalassemia

286. 1 yes 2 no Other

287. Specify genetic disease:

The following questions 288–297 apply only to allogeneic non-NMDP donors. If the stem cell product was from an autologous donor or NMDP donor, or was a cord blood unit, then continue with question 298.

288. Was the donor hospitalized (inpatient) during or after the collection?

- 1 yes
- 2 no

289. Did the donor experience any life-threatening complications during or after the collection?

- 1 yes
- 2 no

290. Specify complications:

291. Did the donor receive blood transfusions as a result of the collection?

- 1 yes
- 2 no

292. Was the blood transfusion product autologous?

- 1 yes
- 2 no

293. Specify number of units:

294. Was the blood transfusion product allogeneic (homologous)?

- 1 yes
- 2 no

295. Specify number of units:

296. Did the donor die as a result of the collection?

- 1 yes
- 2 no

297. Specify cause of death:

298. (Related donors only) Did the recipient submit a research sample?

- 1 yes
- 2 no

299. Research sample recipient ID:

300. (Related donors only) Did the donor submit a research sample?

- 1 yes
- 2 no

301. Research sample donor ID:

302. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____