

# ERROR CORRECTION FORM

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## Acute Myelogenous Leukemia Pre-HSCT Data

### Registry Use Only

Sequence Number:

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Date Received:

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CIBMTR Center Number:

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Date of HSCT for which this form is being completed:

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

Product type:    marrow    PBSC    cord blood    other product, specify: \_\_\_\_\_

**This form must be accompanied by Form 2000 – Recipient Baseline Data. All information in the box above, including the date, should be identical with the corresponding Form 2000. Information should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HSCT, or abstraction of the recipient's medical records.**

**Questions followed by the symbol indicate additional information necessary to complete the question is referenced in the forms instruction manual.**

**If this is a report of a second or subsequent transplant, check here  and continue with question 152.**

### Disease Assessment at Diagnosis

1. What was the date of diagnosis of Acute Myelogenous Leukemia?

|       |     |      |  |  |  |
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2. Was this a secondary (therapy-linked) leukemia? (*not MDS / MPS*)

- 1  yes →  
2  no

3. What was the recipient's prior disease (malignant or nonmalignant):

- 1  breast cancer  
2  Hodgkin lymphoma  
3  non-Hodgkin lymphoma  
4  other →

4. Specify disease: \_\_\_\_\_

5. What was the date of diagnosis of prior disease?

|       |     |      |  |  |  |
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Specify treatment(s) for prior disease:

6. 1  yes 2  no 3  unknown    Chemotherapy  
7. 1  yes 2  no 3  unknown    Radiation  
8. 1  yes 2  no 3  unknown    Other treatment →

9. Specify treatment: \_\_\_\_\_

10. Did the recipient have a documented antecedent hematologic disorder (preleukemia or myelodysplastic syndrome)?

- 1  yes →  
2  yes, MDS suspected and/or concurrent with AML diagnosis  
3  no

11. What was the date of diagnosis of antecedent hematologic disorder?

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12. What was the classification of hematologic disorder at diagnosis?

- 1  refractory anemia (RA)  
2  refractory anemia with ringed sideroblasts (RARS)  
3  refractory anemia with excess blasts (RAEB-1)



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25. Were cytogenetics tested (conventional or FISH)?

- 1  yes  
 2  no  
 3  unknown

26. Results of test at diagnosis:

- 1  yes abnormalities identified  
 2  no evaluable metaphases  
 3  no abnormalities

Complete questions 28–58 in the table below

27. Results of tests after diagnosis and prior to the preparative regimen:

- 1  yes abnormalities identified  
 2  no evaluable metaphases on any tests  
 3  no abnormalities on any tests after diagnosis and before the preparative regimen

Complete questions 59–89 in the table below

Specify abnormalities identified:

| Cytogenetic abnormality              | At diagnosis   | Any test result between diagnosis and preparative regimen        |
|--------------------------------------|--|--|
| <b>Monosomy</b>                      |  |  |
| -5                                   | 28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 59. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| -7                                   | 29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 60. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| -17                                  | 30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| -18                                  | 31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 62. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| -X                                   | 32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 63. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| -Y                                   | 33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 64. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| <b>Trisomy</b>                       |  |  |
| +4                                   | 34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 65. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +8                                   | 35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 66. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +11                                  | 36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 67. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +13                                  | 37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 68. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +14                                  | 38. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 69. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +21                                  | 39. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 70. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| +22                                  | 40. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 71. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| <b>Translocation</b>                 |  |  |
| t(3;3)                               | 41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 72. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| t(6;9)                               | 42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 73. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| t(8;21)                              | 43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 74. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| t(15;17) and variants                | 44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 75. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| t(16;16)                             | 45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 76. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| <b>Deletion</b>                      |  |  |
| del(5q) / 5q-                        | 46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 77. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| del(7q) / 7q-                        | 47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 78. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| del(9q) / 9q-                        | 48. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 79. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| del(11q) / 11q-                      | 49. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 80. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| del(17q) / 17q-                      | 50. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 81. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| del(20q) / 20q-                      | 51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 82. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| <b>Inversion</b>                     |  |  |
| inv(3)                               | 52. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 83. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| inv(16)                              | 53. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| <b>Other</b>                         |  |  |
| (11q23) balanced abnormality         | 54. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 85. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| 12p any abnormality                  | 55. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 86. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| complex (≥ 3 distinct abnormalities) | 56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 87. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| other abnormality                    | 57. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no | 88. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no |
| specify other abnormality:           | 58. _____  | 89. _____  |

90. Is a copy of the cytogenetic or FISH report attached?

- 1  yes  
 2  no

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91. Was a flt-3 ligand mutation present at diagnosis?

- 1  yes
- 2  no
- 3  unknown

## Pre-HSCT Treatment for Acute Myelogenous Leukemia

92. Was therapy given between diagnosis and the start of the preparative regimen?

- 1  yes →
- 2  no

|   | 1st Line of Therapy  | 2nd Line of Therapy   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
|---|--|---|------|-------|-----|---|--|-------|-------|------|------|--|--|---|--|--|--|--|--|--|-------|-----|------|------|--|--|
| Purpose of therapy:                                       | 93. 1 <input type="checkbox"/> induction<br>2 <input type="checkbox"/> consolidation<br>3 <input type="checkbox"/> maintenance<br>4 <input type="checkbox"/> treatment for disease relapse   | 122. 1 <input type="checkbox"/> induction<br>2 <input type="checkbox"/> consolidation<br>3 <input type="checkbox"/> maintenance<br>4 <input type="checkbox"/> treatment for disease relapse |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| <b>Systemic / Intrathecal Therapy:</b>                    |  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date therapy started:                                     | 94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with 112<br>95. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>                     |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 123. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 141<br>124. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>   |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date therapy stopped:                                     | 96. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>  |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 125. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>  |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Number of cycles:   | 97. <table border="1" style="display: inline-table; width: 40px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td></tr></table> <input type="checkbox"/> unknown/not applicable   |   |      | Month | Day | 126. <table border="1" style="display: inline-table; width: 40px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td></tr></table> <input type="checkbox"/> unknown/not applicable |  |       | Month | Day  |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
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| Month   | Day  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| all-trans retinoic acid                                   | 98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   | 127. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| cytarabine ≤ 2 g/m <sup>2</sup> /day                      | 99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   | 128. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| cytarabine > 2 g/m <sup>2</sup> /day                      | 100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 129. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| daunorubicin (Cerubidine)                                 | 101. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 130. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| doxorubicin (Adriamycin)                                  | 102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 131. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| etoposide (VP-16, VePesid)                                | 103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 132. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| gemtuzumab (Mylotarg)                                     | 104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 133. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| idarubicin (Idamycin)                                     | 105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 134. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| intrathecal therapy                                       | 106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 135. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| mitoxantrone (Novantrone)                                 | 107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 136. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| thioguanine (6-TG)  | 108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 137. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| topotecan (Hycamtin)                                      | 109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 138. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| other chemotherapy  | 110. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 139. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| specify other chemotherapy                                | 111. _____   | 140. _____  |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| <b>Radiation Therapy:</b>                                 |  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date therapy started:                                     | 112. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with 118<br>113. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>                   |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 141. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 147<br>142. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>   |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
|   |  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date therapy stopped:                                     | 114. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>   |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 143. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>  |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| central nervous system                                    | 115. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 144. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| other site  | 116. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 145. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| specify other site  | 117. _____   | 146. _____  |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| <b>Best Response to Line of Therapy:</b>                  |  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date response established:                                | 118. 1 <input type="checkbox"/> complete response<br>2 <input type="checkbox"/> no complete response<br>119. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table> |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 147. 1 <input type="checkbox"/> continuous complete response<br>2 <input type="checkbox"/> complete response<br>3 <input type="checkbox"/> no complete response<br>148. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table> |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
|   |  |   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Did the recipient relapse following this line of therapy? | 120. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no  | 149. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no   |      |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
| Date of relapse:  | 121. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>   |   |      |       |     |   |  | Month | Day   | Year | Year |  |  | 150. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td style="font-size: 8px;">Month</td><td style="font-size: 8px;">Day</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;">Year</td><td style="font-size: 8px;"></td><td style="font-size: 8px;"></td></tr></table>  |  |  |  |  |  |  | Month | Day | Year | Year |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |
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| Month   | Day  | Year  | Year |       |     |   |  |       |       |      |      |  |  |   |  |  |  |  |  |  |       |     |      |      |  |  |

Copy this page to report more than 2 lines of therapy; check here  if additional pages are attached.

