

ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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Initials:

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Today's Date:

		2	0		
Month	Day	Year	Year		

Infusion Date:

		2	0		
Month	Day	Year	Year		

CIBMTR Center Number:

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Fanconi Anemia / Constitutional Anemia 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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		2	0		
Month	Day	Year	Year		

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

		2	0		
Month	Day	Year	Year		

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.

If this is a report of a second or subsequent transplant, check here and continue with question 153.

1. What was the date of diagnosis of Fanconi Anemia?

2. Was the diagnosis made in utero?

- 1 yes
2 no

Specify test(s) performed to identify disease:

3. 1 yes 2 no Amniocentesis
4. 1 yes 2 no Chorionic villous sampling (CVS)
5. 1 yes 2 no Fibroblasts
6. 1 yes 2 no Other test

7. If yes, specify other test: _____

8. Was the recipient diagnosed with any congenital abnormalities?

- 1 yes
2 no

Specify test(s) performed to identify disease:

9. 1 yes 2 no Abnormal facies (snub nose, thick upper lip, epicanthic folds, hypertelorism)
10. 1 yes 2 no Ear abnormalities
11. 1 yes 2 no Eye abnormalities (strabismus, cataract, microphthalmia)
12. 1 yes 2 no Other neurologic abnormalities
13. If yes, specify: _____
14. 1 yes 2 no Microcephaly
15. 1 yes 2 no Palate or jaw abnormalities (cleft palate and/or lip, Pierre Robin syndrome, small jaw or mouth)
16. 1 yes 2 no Abnormal neck (short or webbed neck)
17. 1 yes 2 no Cardiac abnormalities
18. 1 yes 2 no Exocrine pancreatic deficiency
19. 1 yes 2 no Gastrointestinal abnormalities
20. 1 yes 2 no Genital abnormalities (cryptorchism, hypoplasia)
21. 1 yes 2 no Kidney or urinary tract abnormalities
22. 1 yes 2 no Thumb abnormalities
23. 1 yes 2 no Radius abnormalities

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24.	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Other skeletal abnormalities (syndactyly, clinodactyly, abnormal ribs, metaphyseal dyschondroplasia)	
25.	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Cafe au lait spots	
26.	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Other skin abnormalities → <table border="1" style="width: 80%;"><tr><td>27. If yes, specify: _____</td></tr></table>	27. If yes, specify: _____
27. If yes, specify: _____						
28.	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Other congenital abnormalities → <table border="1" style="width: 80%;"><tr><td>29. If yes, specify: _____</td></tr></table>	29. If yes, specify: _____
29. If yes, specify: _____						

30. Specify the date that abnormal blood results were first observed:

--	--

--	--

--	--	--	--

Month Day Year

31. Specify the presenting hematologic disorder:

1 acute leukemia → **Complete a corresponding Leukemia insert**

2 cytopenia →

Specify cytopenia:
32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Anemia (Hb < 10 g/dL)
33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Thrombocytopenia (platelets < 100,000/mm ³)
34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no neutropenia (ANC < 1,000/mm ³)

3 myelodysplasia → **Complete a Form 2014 – MDS insert**

4 other disorder →

35. Specify other hematologic disorder: _____

36. Was the bone marrow examined at diagnosis?

1 yes →

37. Specify date of bone marrow examination:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td></td><td></td><td></td><td></td></tr></table>				
	Month	Day	Year								

2 no

3 unknown

38. Specify cellularity:

1 decreased

2 normal

3 increased

4 unknown

39. Were dysplastic features present at diagnosis?

1 yes

2 no

3 unknown

40. Blasts in marrow:

--	--	--	--

 %

Cytogenetic Studies / Sensitivity to DNA Cross-Linking Agents

This section requests information about bone marrow karyotype and examination of bone marrow and blood cells for non-specific chromatid abnormalities. If more than one investigation was carried out, please copy this section and report each event separately.

41. Was bone marrow karyotyping performed at diagnosis?

1 yes →

42. Was karyotype normal?	<input type="checkbox"/>	yes
2 <input type="checkbox"/> no →		Specify abnormalities identified:
43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	+4	
44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	+5	
45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	-7	
46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	+8	
47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	+11	

2 yes, but no evaluable metaphases

3 no

4 unknown

CIBMTR Form 2029 (FAN) v1.0 (2-8) July 2007
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Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

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Month	Day	Year							

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Month	Day	Year							

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48.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	+13		
49.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	+14		
50.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	-17		
51.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	-18		
52.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	-20		
53.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	+21		
54.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	+22		
55.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	-X		
56.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	-Y		
57.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	del(5q)		
58.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	del(7q)		
59.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	del(9q)		
60.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	del(11q)		
61.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	del(20q)		
62.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	inv(3) or t(3;3)		
63.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	inv(16) or t(16;16)		
64.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(1;7)		
65.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(5;7)		
66.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(6;9)		
67.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(8;16)		
68.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(8;21)		
69.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(15;17) and variants		
70.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	balanced abn(11q23)		
71.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	abn(12p)		
72.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	loss of 17p		
73.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	complex (≥ 3 distinct abnormalities)		
74.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	increased breaks		
75.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	other karyotype abnormality		
76.	Specify other abnormality: _____								
77.	Date of karyotyping:								
		Month	Day	Year					

78. Is a copy of the cytogenetic report attached?

- 1 yes
2 no

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79. Was complementation group testing performed at any time prior to the preparative regimen?

- 1 yes
2 no

Specify groups identified:

80. 1 yes 2 no FANCA

81. 1 yes 2 no FANCB

82. 1 yes 2 no FANCC

83. 1 yes 2 no FANCD2

84. 1 yes 2 no FANCE

85. 1 yes 2 no FANCF

86. 1 yes 2 no FANCG

87. 1 yes 2 no Other group →

89. Is a copy of the complementation group report attached?

1 yes
2 no

90. Were any genetic mutations identified?

- 1 yes
2 no

Specify mutation origin:

91. 1 yes 2 no maternal →

92. 1 yes 2 no paternal →

93. Was a mutation analysis of cloned Fanconi Anemia genes performed at any time prior to the preparative regimen?

- 1 yes
2 no
3 unknown

94. Specify the date the analysis was performed:

Month	Day	Year			

Specify mutation(s):

95. 1 yes 2 no Exon → Specify value:

97. 1 yes 2 no Intron → Specify value:

99. 1 yes 2 no Nucleotide change (e.g., 732G>C) → Specify:

101. 1 yes 2 no Amino acid changes (e.g., L244F) → Specify:

103. Specify the mutation type:

1 substitution
2 deletion
3 insertion

104. Is a copy of the mutation analysis report attached?

1 yes
2 no

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105. Were the recipient's bone marrow cells or peripheral blood mononuclear cells tested for sensitivity to cross-linking agents?

- 1 yes
 2 no
 3 unknown

106. Specify the date the testing was performed:

--	--

 /

--	--

 /

--	--	--	--

107. Specify the type of cross-linking agent used:
 1 diepoxybutane (DEB)
 2 mitomycin C
 3 other agent >

--

108. Specify other agent:

--

109. Were chromatid aberrations present on an *unstressed* preparation?
 1 yes
 2 no
 3 not evaluable

110. Total number of cells studied:

--	--

111. Number of aberrations per cell:

--	--	--	--

112. Number of cells with no aberrations:

--	--

113. Were chromatid aberrations present on a *stressed* preparation?
 1 yes
 2 no
 3 not evaluable

114. Total number of cells studied:

--	--

115. Number of aberrations per cell:

--	--	--	--

116. Number of cells with no aberrations:

--	--

117. Is a copy of the report attached?
 1 yes
 2 no

Familial History of Disease

118. Were any other genetically related family members affected?

- 1 yes
 2 no
 3 unknown

Specify family member(s):

119. 1 yes 2 no Sibling

120. 1 yes 2 no Cousin

121. 1 yes 2 no Parent

122. 1 yes 2 no Aunt / uncle

123. 1 yes 2 no Other relative >

--

124. Specify relationship:

--

125. Is the recipient genetically related to his / her parents?

- 1 yes, both mother and father
 2 yes, mother only
 3 yes, father only
 4 no, not genetically related to mother or father
 5 unknown

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Today's Date:

<input type="text"/>	<input type="text"/>	20	<input type="text"/>	<input type="text"/>
Month	Day	Year		

Infusion Date:

<input type="text"/>	<input type="text"/>	20	<input type="text"/>	<input type="text"/>
Month	Day	Year		

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

126. (Related donors only) Were the donor's blood or bone marrow cells tested for sensitivity to cross-linking agents?

- 1 yes
2 no
3 unknown

127. Specify the date testing was performed:
Month Day Year

128. Specify the type of cross-linking agent used:

- 1 diepoxybutane (DEB)
2 mitomycin C
3 other agent

129. Specify other agent:

130. Were chromatid aberrations present on an *unstressed* preparation?

- 1 yes
2 no
3 not evaluable

131. Total number of cells studied:

132. Number of aberrations per cell:

133. Number of cells with no aberrations:

134. Were chromatid aberrations present on a stressed preparation?

- 1 yes
2 no
3 not evaluable

135. Total number of cells studied:

136. Number of aberrations per cell:

137. Number of cells with no aberrations:

138. Is a copy of the report attached?

- 1 yes
2 no

139. Was the recipient treated with androgens prior to the HSCT?

- 1 yes
2 no
3 unknown

140. Was the recipient treated with corticosteroids prior to the HSCT?

- 1 yes
2 no
3 unknown

141. Did the recipient receive growth factors prior to the HSCT?

- 1 yes
2 no
3 unknown

If yes, specify cytokine(s) given:

142. 1 yes 2 no Erythropoietin (includes all forms of erythropoietin / darbepoetin)

143. 1 yes 2 no G-CSF

144. 1 yes 2 no GM-CSF

145. 1 yes 2 no IL3

146. 1 yes 2 no Neulasta

147. 1 yes 2 no Stem cell factor

148. 1 yes 2 no Other growth factor

149. Specify other agent:

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177.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	t(1;7)		
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187.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	increased breaks		
188.	1	<input type="checkbox"/>	yes	2	<input type="checkbox"/>	no	other karyotype abnormality		
189.	Specify other abnormality: _____								
190.	Date of karyotyping:								
			Month	Day	Year				

191. Is a copy of the cytogenetic report attached?

- 1 yes
2 no

192. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____