

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			

Infusion Date:

		2	0		
Month	Day	Year			

CIBMTR Center Number:

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Immune Deficiencies Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

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CIBMTR Center Number:

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CIBMTR Recipient ID:

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Today's Date:

		2	0		
Month	Day	Year			

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

		2	0		
Month	Day	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 5.

1. What was the date of diagnosis of Immune Deficiency?

 /

 /

2. What is the immune deficiency phenotype?
- 1 SCID: ADA deficiency (< 5% ADA enzyme activity in red blood cells [if patient has not been transfused], or in white blood cells)
 - 2 SCID: absence of T-cells with normal B-cells (This phenotype is X-linked. T-cell number in the absence of maternal engraftment < 100/mm³, B-cells are slg+ and normal in absolute number for age — **or** — defined mutation in IL-2R gamma chain gene.)
 - 3 SCID: absence of T- and B-cells (Total absolute lymphocyte count < 500/mm³, frequently < 200/mm³, T- or B-cells < 100/mm³. Patients with very low numbers of T- and B-cells but a greater proportion of NK cells should be listed as "other.")
 - 4 other phenotype (include Omenn's syndrome, ZAP 70 deficiency, IL2 deficiency, CD7 deficiency, SCID with NK cells, and others) → 3. Specify other phenotype: _____

4. What is the inheritance of immune deficiency?
- 1 X-linked (family history is positive, or recipient has been documented to have a defect of an X-linked gene causing SCID)
 - 2 autosomal recessive (all females; males in families with affected females)
 - 3 acquired (not inherited)
 - 4 unknown

Hematologic Findings Prior to HSCT

- | | | | |
|------------------------------------|---|------------------|----------------------------------|
| 5. T-cells (CD3 or equivalent): | <table border="1" style="width: 20px; height: 20px;"></table> | % of lymphocytes | <input type="checkbox"/> unknown |
| 6. CD4+ cells: | <table border="1" style="width: 20px; height: 20px;"></table> | % of lymphocytes | <input type="checkbox"/> unknown |
| 7. CD8+ cells: | <table border="1" style="width: 20px; height: 20px;"></table> | % of lymphocytes | <input type="checkbox"/> unknown |
| 8. B-cells (CD19+, CD20+, slg+): | <table border="1" style="width: 20px; height: 20px;"></table> | % of lymphocytes | <input type="checkbox"/> unknown |
| 9. NK cells (CD16+ or equivalent): | <table border="1" style="width: 20px; height: 20px;"></table> | % of lymphocytes | <input type="checkbox"/> unknown |

CIBMTR Form 2031 (ID) v1.0 (1–2) July 2007
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Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

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Clinical Status of Recipient Immediately Prior to HSCT

10. Was maternal engraftment present?

- 1 yes
2 no
3 unknown / not tested

11. Was graft vs. host disease present?

- 1 yes
2 no

Specify cause(s) of disease:

12. 1 yes 2 no Maternal cells
13. 1 yes 2 no Unirradiated blood transfusions
14. 1 yes 2 no Source unknown

15. Did the recipient have failure to thrive? (decrease of 0.5 standard deviation in weight on standard growth curve or weight < 5th percentile for age)

- 1 yes
2 no
3 unknown

16. Did the recipient have chronic (protracted) diarrhea > 6 weeks in duration?

- 1 yes
2 no
3 unknown

17. Did the recipient have respiratory impairment? (need for chronic or intermittent support with O₂ or artificial ventilation and/or presence of persistent interstitial, nodular or lobar pneumonia)

- 1 yes
2 no
3 unknown

18. Has the recipient developed an EBV-associated B-cell lymphoproliferative disorder?

- 1 yes
2 no
3 unknown

19. Specify the date of diagnosis:

		2	0		
Month	Day	Year			

20. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____