

# 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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## Wiscott-Aldrich Syndrome 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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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 7.**

1. What was the date of diagnosis of Wiscott-Aldrich Syndrome (WAS)?

Month	Day	Year					

Specify the WAS defining (diagnostic) criteria:

- yes  no  unknown Eczema
- yes  no  unknown Platelet count (prior to splenectomy) < 150 x 10<sup>9</sup>/L
- yes  no  unknown Small platelet size (average < 2 μ in diameter or mean platelet volume < 8.5 fL)
- yes  no  unknown X-linked inheritance demonstrated in family; i.e., affected male but unaffected female relatives
- Was the diagnosis confirmed by molecular identification of the presence of a defect in the WAS gene?
  - yes
  - no
  - unknown

### Clinical Status of Recipient Prior to HSCT

7. Did the recipient undergo a splenectomy prior to HSCT?

- yes
- no
- unknown

8. Was the recipient's platelet count normal immediately prior to HSCT?

- yes
- no
- unknown

9. Did the recipient develop any autoimmune complications prior to HSCT?

- yes
- no
- unknown

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		2	0		
Month	Day	Year			

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		2	0		
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## Clinical Status of Recipient Prior to Preparative Regimen

10. Did the recipient experience 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
11. Did the recipient experience chronic diarrhea (protracted, > 6 weeks in duration) in year prior to HSCT?
- 1  yes  
2  no  
3  unknown
12. Did the recipient experience respiratory impairment? (*need for chronic or intermittent support with O<sub>2</sub> or artificial ventilation and/or presence of persistent interstitial, nodular, or lobar pneumonia*)
- 1  yes  
2  no  
3  unknown

13. Signed: \_\_\_\_\_  
*Person completing form*

Please print name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_