

# ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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

Initials:

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

Today's Date:

		2	0		
Month	Day	Year			

Infusion Date:

		2	0		
Month	Day	Year			

CIBMTR Center Number:

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



## Congenital Amegakaryocytic Thrombocytopenia 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:

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

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 25.**

1. What was the date abnormal platelet counts were first observed?

Month	Day	Year			

2. What was the date of diagnosis of Congenital Amegakaryocytic Thrombocytopenia?

Month	Day	Year			

### Hematologic Findings at Diagnosis

3. WBC:

1  known → 

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2  not known

Specify units:

1  x 10<sup>9</sup>/L (x 10<sup>3</sup>/mm<sup>3</sup>)  
2  x 10<sup>6</sup>/L

4. Hemoglobin (untransfused):

1  known → 

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2  not known

1  g/dL  
2  g/L  
3  mmol/L

5. Platelets (untransfused):

1  known → 

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2  not known

1  x 10<sup>9</sup>/L (x 10<sup>3</sup>/mm<sup>3</sup>)  
2  x 10<sup>6</sup>/L

6. Neutrophils:

1  known → 

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 %

2  not known

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

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CIBMTR Recipient ID:

Initials:

Today's Date:

  
Month Day  
  
2 0  
Year

Infusion Date:

  
Month Day  
  
2 0  
Year

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

7. Was the bone marrow examined at diagnosis?

- 1  yes  
2  no

8. Specify the date the bone marrow was examined:

  
Month Day  
  
Year

9. What was the cellularity of the bone marrow at diagnosis?

- 1  decreased  
2  normal  
3  increased

10. What was the megakaryocyte level in the bone marrow at diagnosis?

- 1  decreased  
2  absent

11. Were radiographs of radii performed at diagnosis?

- 1  yes  
2  no  
3  unknown

12. Were the radii present?

- 1  yes  
2  no

13. Did the radii appear normally developed?

- 1  yes  
2  no

## Family History of Thrombocytopenia

14. Did the recipient's mother develop thrombocytopenia while pregnant with the recipient?

- 1  yes  
2  no  
3  unknown

15. Was the mother tested for the presence of GPIIIA platelet antigen?

- 1  yes  
2  no

16. Specify results:

- 1  GPIIIA platelet antigen present  
2  GPIIIA platelet antigen absent

17. Have any of the recipient's family members been diagnosed with thrombocytopenia?

- 1  yes  
2  no  
3  unknown

Specify relationship to recipient:

18. 1  yes 2  no Aunt / uncle  
19. 1  yes 2  no Cousin  
20. 1  yes 2  no Parent  
21. 1  yes 2  no Sibling  
22. 1  yes 2  no Other blood relative

23. Specify relationship: \_\_\_\_\_

24. Do the recipient's parents share a close degree of consanguinity (descent from common ancestors / interfamilial marriage)?

- 1  yes  
2  no

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Sequence Number:

CIBMTR Recipient ID:

Initials:

Today's Date:

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

Infusion Date:

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

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

## Disease Treatment Prior to the Preparative Regimen

25. Did the recipient receive any treatment(s) for CAT at any time prior to the preparative regimen?

- 1  yes  
2  no

Specify treatment(s) given:

26. Androgens

- 1  yes  
2  no

27. Growth factors

- 1  yes  
2  no

Specify growth factors given:

28. 1  yes 2  no Erythropoietin (all formulations)  
29. 1  yes 2  no G-CSF (all formulations)  
30. 1  yes 2  no GM-CSF  
31. 1  yes 2  no Neumega (oprelvekin, IL-11)  
32. 1  yes 2  no Thrombopoietin  
33. 1  yes 2  no Other →

34. Specify:

35. Steroids

- 1  yes  
2  no

36. Transfusions

- 1  yes  
2  no

37. Specify the number of red blood cell transfusions given (best estimate):  units

38. Were single donor platelet transfusions given?

- 1  yes  
2  no  
3  unknown

39. Specify the total number of aphereses:

40. Were random donor platelet transfusions given?

- 1  yes  
2  no  
3  unknown

41. Specify the total number of donors:

42. Other treatment

- 1  yes  
2  no

43. Specify:

44. Did the recipient undergo a splenectomy at any time prior to the preparative regimen?

- 1  yes  
2  no

45. Was there any evidence of allosensitization at any time prior to the preparative regimen?

- 1  yes  
2  no  
3  unknown

46. Specify the method of allosensitization identification:

- 1  inadequate rise in platelet count to transfusion  
2  anti-platelet antibodies developed  
3  antibodies to HLA antigens

47. Did the recipient develop myelodysplastic syndrome (MDS) or acute myeloid leukemia (AML) at any time prior to the preparative regimen?

- 1  yes  
2  no  
3  unknown

**Complete this report through question 48 below, skip questions 49–115, and complete the signature lines at question 116. Also complete an MDS or AML insert from diagnosis through post-HSCT, and continue all follow-up reporting using MDS or AML inserts.**

48. Is a completed MDS or AML insert attached to this report?

- 1  yes  
2  no

