

# ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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Initials:

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Today's Date:

<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Month</p>		<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Day</p>		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">0</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table> <p style="text-align: center; font-size: small;">Year</p>	2	0				
2	0									

Infusion Date:

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2	0									

CIBMTR Center Number:

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## Rheumatoid Arthritis Pre-HSCT Data

### Registry Use Only

Sequence Number:

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Date Received:

CIBMTR Center Number:

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CIBMTR Recipient ID:

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Today's Date:

<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Month</p>		<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Day</p>		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">0</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table> <p style="text-align: center; font-size: small;">Year</p>	2	0				
2	0									

Date of HSCT for which this form is being completed:

<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Month</p>		<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 100%;"></td></tr> </table> <p style="text-align: center; font-size: small;">Day</p>		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">0</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table> <p style="text-align: center; font-size: small;">Year</p>	2	0				
2	0									

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 78.**

### Disease Assessment at Diagnosis

1. What was the date of diagnosis of Rheumatoid Arthritis? 

Month	Day	Year			

 date unknown

2. Did recipient meet the American Rheumatism Association criteria for rheumatoid arthritis? (see definition)

- 1  yes
- 2  no
- 3  unknown

*Arnett et al, Arthritis Rheum 1988, 31:315*

*4 or more criteria must be present to classify a patient as having rheumatoid arthritis*

- *Morning stiffness for at least 1 hour and present for at least 6 weeks*
- *Swelling of 3 or more joints for at least 6 weeks*
- *Swelling of wrist, metacarpophalangeal or proximal interphalangeal joints for 6 or more weeks*
- *Symmetric joint swelling*
- *Hand roentgenogram changes typical of rheumatoid arthritis that must include erosions or unequivocal bony decalcification*
- *Rheumatoid nodules*
- *Serum rheumatoid factor by a method positive in < 5% of normals*

3. Did patient ever have positive titers of serum rheumatoid factor?

- 1  yes
- 2  no
- 3  unknown

4. Specify titers:

- 1  IgG
- 2  IgM
- 3  IgA
- 4  unknown

5. Was HLA-DRB1 testing performed?

- 1  yes
- 2  no
- 3  unknown

6. Specify DRB1 allele: \_\_\_\_\_

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

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2	0											
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2	0											
Month	Day	Year										

CIBMTR Center Number:

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## Pre-HSCT Treatment for Rheumatoid Arthritis

7. Did the recipient receive any disease-modifying treatments between the time of diagnosis and prior to mobilization for stem cell collection (or high-dose therapy if mobilization was not done)?

1  yes → Continue with table below

2  no → Continue with question 71

Codes for Treatment Stopped			
1 Failure	2 Toxicity	3 Other reason	4 Reason unknown

Treatment Given?	Treatment Stopped?	Stopped Code	
<b>8. Anti-tumor necrosis factor (TNF)</b>			
1 <input type="checkbox"/> yes →	9. 1 <input type="checkbox"/> yes →	10. <input type="text"/>	11. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>12. Azathioprine</b>			
1 <input type="checkbox"/> yes →	13. 1 <input type="checkbox"/> yes →	14. <input type="text"/>	15. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>16. Corticosteroids</b>			
1 <input type="checkbox"/> yes →	17. 1 <input type="checkbox"/> yes →	18. <input type="text"/>	19. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>20. Cyclophosphamide</b>			
1 <input type="checkbox"/> yes →	21. 1 <input type="checkbox"/> yes →	22. <input type="text"/>	23. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>24. Cyclosporin A</b>			
1 <input type="checkbox"/> yes →	25. 1 <input type="checkbox"/> yes →	26. <input type="text"/>	27. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>28. Gold-IM</b>			
1 <input type="checkbox"/> yes →	29. 1 <input type="checkbox"/> yes →	30. <input type="text"/>	31. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>32. Gold-PO</b>			
1 <input type="checkbox"/> yes →	33. 1 <input type="checkbox"/> yes →	34. <input type="text"/>	35. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>36. Hydroxychloroquine</b>			
1 <input type="checkbox"/> yes →	37. 1 <input type="checkbox"/> yes →	38. <input type="text"/>	39. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			
<b>40. Leflunomide</b>			
1 <input type="checkbox"/> yes →	41. 1 <input type="checkbox"/> yes →	42. <input type="text"/>	43. If code 3, specify other reason: _____
2 <input type="checkbox"/> no	2 <input type="checkbox"/> no		
3 <input type="checkbox"/> unknown			

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Today's Date:

Infusion Date:

CIBMTR Center Number:

<table border="1" style="width: 100%; height: 27px;"></table>	<table border="1" style="width: 100%; height: 27px;"></table>	<table border="1" style="width: 100%; height: 27px; text-align: center;">20</table>
Month	Day	Year

<table border="1" style="width: 100%; height: 27px;"></table>	<table border="1" style="width: 100%; height: 27px;"></table>	<table border="1" style="width: 100%; height: 27px; text-align: center;">20</table>
Month	Day	Year

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CIBMTR Center Number:

CIBMTR Recipient ID:

Treatment Given?	Treatment Stopped?	Stopped Code	
44. Methotrexate 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	46. <table border="1" style="width: 20px; height: 20px;"></table>	47. If code 3, specify other reason: _____
	48. Maximum weekly dose of methotrexate: 1 <input type="checkbox"/> known 2 <input type="checkbox"/> not known	→ <table border="1" style="width: 40px; height: 20px;"></table> mg	
	49. Duration of methotrexate therapy: 1 <input type="checkbox"/> known 2 <input type="checkbox"/> not known	→ <table border="1" style="width: 40px; height: 20px;"></table> months	
50. Minocycline 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	52. <table border="1" style="width: 20px; height: 20px;"></table>	53. If code 3, specify other reason: _____
54. Penicillamine 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	55. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	56. <table border="1" style="width: 20px; height: 20px;"></table>	57. If code 3, specify other reason: _____
58. Rituximab 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	59. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	60. <table border="1" style="width: 20px; height: 20px;"></table>	61. If code 3, specify other reason: _____
62. Sulfasalazine 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	63. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	64. <table border="1" style="width: 20px; height: 20px;"></table>	65. If code 3, specify other reason: _____
66. Other treatment 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	67. Specify other treatment: _____		
	68. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	69. <table border="1" style="width: 20px; height: 20px;"></table>	70. If code 3, specify other reason: _____
71. Did the recipient stop receiving disease-modifying drugs (e.g., cyclophosphamide, methotrexate, etc.) or anti-TNF regimen (not NSAIDS) prior to mobilization for stem cell collection (or high-dose therapy if mobilization was not done)? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	72. Specify the date that the recipient last received disease-modifying drugs or anti-TNF regimen: <table border="1" style="width: 40px; height: 20px;"></table> <table border="1" style="width: 40px; height: 20px;"></table> <table border="1" style="width: 40px; height: 20px; text-align: center;">20</table> <input type="checkbox"/> date unknown Month Day Year		
73. Was the recipient receiving non-steroidal anti-inflammatory drugs (NSAIDS) within 4 weeks of mobilization for stem cell collection (or high-dose therapy if mobilization was not done)? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	74. Were the NSAIDS discontinued prior to mobilization? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown		
	75. Specify the date NSAIDS were stopped: <table border="1" style="width: 40px; height: 20px;"></table> <table border="1" style="width: 40px; height: 20px;"></table> <table border="1" style="width: 40px; height: 20px; text-align: center;">20</table> <input type="checkbox"/> date unknown Month Day Year		
	76. Specify the reason for stopping (see Codes for Treatment Stopped on previous page): <table border="1" style="width: 20px; height: 20px;"></table>		
	77. If code 3, specify other reason: _____		

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Initials:

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Today's Date:

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Month	Day	Year			

Infusion Date:

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Month	Day	Year			

CIBMTR Center Number:

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CIBMTR Recipient ID:

## Pre-Mobilization Evaluation

**Information for this section should come from the most recent evaluation prior to the initiation of mobilization therapy (≤ 4 weeks prior to mobilization for stem cell collection). If the recipient did not receive mobilization therapy, check here  and continue with question 134.**

78. Date of evaluation prior to mobilization for stem cell collection: 

<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>			
Month	Day	Year			

79. Specify the number of painful / tender joints prior to mobilization: *(Eular/ACR 28 joint count; Fuchs and Pincus, Arthritis Rheum, 1994, 37:470. Joints included in 28 joint count are bilateral shoulders, elbows, wrists, MCPs, PIPs and knees.)*



 number unknown

80. Specify the number of swollen / effused joints prior to mobilization: *(Eular/ACR 28 joint count; Fuchs and Pincus, Arthritis Rheum, 1994, 37:470. Joints included in 28 joint count are bilateral shoulders, elbows, wrists, MCPs, PIPs and knees.)*



 number unknown

81. Was morning stiffness present just prior to mobilization?

- 1  yes  
2  no  
3  unknown

82. Specify duration: 

<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>		<table border="1" style="width: 20px; height: 20px;"></table>		
Hours	Minutes	:			

83. Were extra-articular manifestations of RA present just prior to mobilization?

- 1  yes  
2  no  
3  unknown

84. Were nodules present?

- 1  yes  
2  no

85. Were other manifestations present?

- 1  yes  
2  no

86. Specify:

## Laboratory Studies Prior to Mobilization for Stem Cell Collection

Specify if any of the following laboratory values were elevated prior to mobilization:

87. 1  yes 2  no 3  unknown Antinuclear antibody (ANA) titers  
88. 1  yes 2  no 3  unknown C-reactive protein  
89. 1  yes 2  no 3  unknown Erythrocyte sedimentation rate (ESR)  
90. 1  yes 2  no 3  unknown Serum rheumatoid factor (RF) titers

91. Date CBC tested: 

<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>			
Month	Day	Year			

92. WBC: 

<input type="checkbox"/> known	→	<table border="1" style="width: 20px; height: 20px;"></table>			
<input type="checkbox"/> not known			.	<table border="1" style="width: 20px; height: 20px;"></table>	

 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

93. Segs: 

<input type="checkbox"/> known	→	<table border="1" style="width: 20px; height: 20px;"></table>			
<input type="checkbox"/> not known			%		

94. Bands: 

<input type="checkbox"/> known	→	<table border="1" style="width: 20px; height: 20px;"></table>			
<input type="checkbox"/> not known			%		

95. Lymphocytes: 

<input type="checkbox"/> known	→	<table border="1" style="width: 20px; height: 20px;"></table>			
<input type="checkbox"/> not known			%		

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



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Initials:

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:

## Recipient Disability Self-Assessment

112. Did the recipient complete an SF-36 Health Survey prior to mobilization?

- 1  yes  
2  no  
3  unknown

113. How is the score reported?

- 1  transformed score (range 0-100)  
2  raw score  
3  unknown

Specify the following scale scores:

114. Physical Functioning:     .   score unknown

115. Role Functioning-Physical:     .   score unknown

116. Role Functioning-Emotional:     .   score unknown

117. Social Functioning:     .   score unknown

118. Bodily Pain:     .   score unknown

119. Mental Health:     .   score unknown

120. Vitality:     .   score unknown

121. General Health:     .   score unknown

122. Did the recipient complete a Health Assessment Questionnaire (HAQ) prior to mobilization?

- 1  yes  
2  no  
3  unknown

123. Recipient's score:     .

124. Worst possible function score:     .

125. Best possible function score:     .

126. Did the recipient complete a Global Assessment of Functioning of his/her own health prior to mobilization?

- 1  yes  
2  no  
3  unknown

127. Recipient-rated Global Assessment score:     .

128. Worst possible score:     .

129. Best possible score:     .

130. Did the physician complete a Global Assessment of Functioning of the recipient's health prior to mobilization?

- 1  yes  
2  no  
3  unknown

131. Physician-rated Global Assessment score:     .

132. Worst possible score:     .

133. Best possible score:     .

# ERROR CORRECTION FORM

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Initials:

Today's Date:

  
Month Day

20

Year

Infusion Date:

  
Month Day

20

Year

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

## Evaluation Prior to the Preparative Regimen (High-Dose Therapy)

Information for this section should come from the most recent evaluation performed  $\leq 2$  weeks prior to the preparative regimen. If the recipient was not evaluated prior to the preparative regimen, check here  and continue with the signature lines at question 178.

134. Was an assessment performed after mobilization and prior to starting conditioning (high-dose therapy)?

1  yes

2  no

Continue with the signature lines at question 178

135. Date of evaluation prior to the preparative regimen:

  
Month Day

20

Year

136. Specify the number of painful / tender joints prior to the preparative regimen: (*Eular/ACR 28 joint count; Fuchs and Pincus, Arthritis Rheum, 1994, 37:470. Joints included in 28 joint count are bilateral shoulders, elbows, wrists, MCPs, PIPs and knees.*)

number unknown

137. Specify the number of swollen / effused joints prior to the preparative regimen: (*Eular/ACR 28 joint count; Fuchs and Pincus, Arthritis Rheum, 1994, 37:470. Joints included in 28 joint count are bilateral shoulders, elbows, wrists, MCPs, PIPs and knees.*)

number unknown

138. Was morning stiffness present just prior to the preparative regimen?

1  yes

2  no

3  unknown

139. Specify duration:

  
Hours Minutes

140. Were extra-articular manifestations of RA present just prior to the preparative regimen?

1  yes

2  no

3  unknown

141. Were nodules present?

1  yes

2  no

142. Were other manifestations present?

1  yes

2  no

143. Specify: \_\_\_\_\_

Specify if any of the following signs / symptoms were elevated prior to the preparative regimen:

144. 1  yes 2  no 3  unknown Antinuclear antibody (ANA) titers

145. 1  yes 2  no 3  unknown C-reactive protein

146. 1  yes 2  no 3  unknown Erythrocyte sedimentation rate (ESR)

147. 1  yes 2  no 3  unknown Serum rheumatoid factor (RF) titers

## Laboratory Values Prior to the Preparative Regimen

148. Date tested:

  
Month Day

20

Year

(testing done within 30 days of start of preparative regimen)

149. Alkaline phosphatase:

1  known

2  not known

  
• 

1  U/L

2   $\mu$ kat/L

150. Albumin:

1  known

2  not known

  
• 

1  g/dL

2  g/L

151. Were radiographic bone erosions present prior to the preparative regimen?

1  yes

2  no

3  unknown

CIBMTR Form 2041 (RA) v1.0 (7-9) 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

Infusion Date:

 /  /   
Month Day Year

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

## Recipient Pain Self-Assessment

Specify the recipient's assessment of pain level experienced due to disease in the 2 weeks prior to the preparative regimen:

152. Recipient's pain assessment:  .

153. Worst possible pain score:  .

154. Best possible pain score:  .

## Recipient Disability Self-Assessment

155. Did the recipient complete an SF-36 Health Survey prior to the preparative regimen?

- 1  yes  
2  no  
3  unknown

156. How is the score reported?

- 1  transformed score (range 0-100)  
2  raw score  
3  unknown

Specify the following scale scores:

157. Physical Functioning:  .   score unknown

158. Role Functioning-Physical:  .   score unknown

159. Role Functioning-Emotional:  .   score unknown

160. Social Functioning:  .   score unknown

161. Bodily Pain:  .   score unknown

162. Mental Health:  .   score unknown

163. Vitality:  .   score unknown

164. General Health:  .   score unknown

165. Did the recipient complete a Health Assessment Questionnaire (HAQ) prior to the preparative regimen?

- 1  yes  
2  no  
3  unknown

166. Recipient's score:  .

167. Worst possible function score:  .

168. Best possible function score:  .

169. Did the recipient complete a Global Assessment of Functioning of his/her own health prior to the preparative regimen?

- 1  yes  
2  no  
3  unknown

170. Recipient-rated Global Assessment score:  .

171. Worst possible score:  .

172. Best possible score:  .

