

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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Hepatitis Serology Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

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: _____

Information for this report 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.

All questions refer to the period prior to the preparative regimen for the recipient's first HSCT.

Serological Evidence of Prior Hepatitis Exposure / Infection — Recipient

Specify and/or confirm previous hepatitis testing performed and reported on the Form TED — Transplant Essential Data.

- | | | | | | |
|--|-------------------------------------|-------------------------------------|---|---------------------------------------|---|
| 1. Hepatitis B core antibody (HBcAb) | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested | 5 <input type="checkbox"/> confirm prior result |
| 2. Hepatitis B surface antigen (HBsAg) | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested | 5 <input type="checkbox"/> confirm prior result |
| 3. Hepatitis B e antigen (HBeAg) | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested | |
| 4. Hepatitis C antibody (HCAb) | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested | 5 <input type="checkbox"/> confirm prior result |

Provide all documented hepatitis B viral load levels obtained within 3 months prior to the preparative regimen. If no values were obtained in the 3 months prior to the preparative regimen, provide and date the most recent values obtained prior to the preparative regimen.

- | | Month | Day | Year | | | Specify units: |
|----------|-------|-----|------|---|-----------------------------------|--------------------------------------|
| 5. Date: | | | 2 | 0 | 6. Hepatitis B viral load level: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | 3 <input type="checkbox"/> copies/mL |
| | | | | | | 4 <input type="checkbox"/> pg/mL |
| 7. Date: | | | 2 | 0 | 8. Hepatitis B viral load level: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | 3 <input type="checkbox"/> copies/mL |
| | | | | | | 4 <input type="checkbox"/> pg/mL |
| 9. Date: | | | 2 | 0 | 10. Hepatitis B viral load level: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | 3 <input type="checkbox"/> copies/mL |
| | | | | | | 4 <input type="checkbox"/> pg/mL |

Provide all documented hepatitis C viral load levels obtained within 3 months prior to the preparative regimen. If no values were obtained in the 3 months prior to the preparative regimen, provide and date the most recent values obtained prior to the preparative regimen.

- | | Month | Day | Year | | | Specify units: |
|-----------|-------|-----|------|---|-----------------------------|-----------------------------------|
| 11. Date: | | | 2 | 0 | 12. Hepatitis C viral load: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | |
| | | | | | | |
| 13. Date: | | | 2 | 0 | 14. Hepatitis C viral load: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | |
| | | | | | | |
| 15. Date: | | | 2 | 0 | 16. Hepatitis C viral load: | 1 <input type="checkbox"/> log IU |
| | | | | | | 2 <input type="checkbox"/> IU/mL |
| | | | | | | |
| | | | | | | |

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

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Today's Date:

Infusion Date:

CIBMTR Center Number:

<table border="1" style="width: 100%; height: 26px;"></table>	<table border="1" style="width: 100%; height: 26px;"></table>	<table border="1" style="width: 100%; height: 26px; text-align: center;">20</table>
Month	Day	Year

<table border="1" style="width: 100%; height: 26px;"></table>	<table border="1" style="width: 100%; height: 26px;"></table>	<table border="1" style="width: 100%; height: 26px; text-align: center;">20</table>
Month	Day	Year

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CIBMTR Center Number:

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17. Were any liver biopsies performed for cytology and/or pathology prior to HSCT?

- 1 yes → **Attach a copy of liver cytology / pathology report(s).**
 2 no

History of Antiviral Therapy for Hepatitis — Recipient

18. Did the recipient receive therapy for hepatitis prior to HSCT?

- 1 yes → **Continue with table below**
 2 no → **Continue with question 74**

For the therapy table below, see "Reason Started" codes on page 3. Therapy paused for < 1 week should *not* be considered as "Therapy Stopped."

Therapy Given?	Date Started			Daily Dose	Reason Started	Therapy Stopped?	Date Stopped			
Lamivudine										
19. First course	Month	Day	Year	mg	Code		Month	Day	Year	
1 <input type="checkbox"/> yes →	20.	<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>	22. <input type="checkbox"/>	23. 1 <input type="checkbox"/> yes →	24.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				
25. Second course										
1 <input type="checkbox"/> yes →	26.	<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>	28. <input type="checkbox"/>	29. 1 <input type="checkbox"/> yes →	30.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				
31. Third course										
1 <input type="checkbox"/> yes →	32.	<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>	34. <input type="checkbox"/>	35. 1 <input type="checkbox"/> yes →	36.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				
Interferon										
37. First course										
1 <input type="checkbox"/> yes →	38.	<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>	40. <input type="checkbox"/>	41. 1 <input type="checkbox"/> yes →	42.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				
43. Second course										
1 <input type="checkbox"/> yes →	44.	<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>	46. <input type="checkbox"/>	47. 1 <input type="checkbox"/> yes →	48.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				
49. Third course										
1 <input type="checkbox"/> yes →	50.	<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>	52. <input type="checkbox"/>	53. 1 <input type="checkbox"/> yes →	54.	<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>
2 <input type="checkbox"/> no						2 <input type="checkbox"/> no				

Other antiviral therapy

55. Specify other antiviral therapy given: _____
56. First course
- 1 yes → 57.

 58.

 59. 60. 1 yes → 61.
- 2 no
62. Second course
- 1 yes → 63.

 64.

 65. 66. 1 yes → 67.
- 2 no
68. Third course
- 1 yes → 69.

 70.

 71. 72. 1 yes → 73.
- 2 no

Codes for Antiviral Therapy Started			
1 Prophylaxis	2 Empiric therapy due to suspected infection	3 Documented infection	4 Planned post-HSCT therapy

CIBMTR Form 2047 (HEP) v1.0 (2-4) 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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Today's Date:

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Month	Day	Year			

Infusion Date:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>
Month	Day	Year			

CIBMTR Center Number:

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History of Antiviral Therapy for Hepatitis — Donor

90. Did the donor receive therapy for hepatitis prior to the stem cell harvest?

- 1 yes → **Continue with table below**
 2 no → **Continue with question 110**

Therapy Given?	Date Started			Currently Receiving?	Therapy Stopped?	Date Stopped			Reason Stopped Code
	Month	Day	Year			Month	Day	Year	
91. Lamivudine				93. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	95. <table border="1" style="width: 20px; height: 20px;"></table>	96. <table border="1" style="width: 20px; height: 20px;"></table>		
97. Interferon				99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	101. <table border="1" style="width: 20px; height: 20px;"></table>	102. <table border="1" style="width: 20px; height: 20px;"></table>		
103. Other antiviral therapy	104. Specify other therapy: _____								
				106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. <table border="1" style="width: 20px; height: 20px;"></table>	109. <table border="1" style="width: 20px; height: 20px;"></table>		

Codes for Antiviral Therapy Stopped			
1 Planned stop	2 Undesirable side effects	3 Other reason	4 Reason unknown

110. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____