

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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12. Invasive fungal infection

1 yes →

2 no

Specify species of invasive fungal infection:

13. 1 yes 2 no Aspergillus

14. 1 yes 2 no Candida

15. 1 yes 2 no Other species →

16. If yes, specify other fungus: _____

17. Pneumocystis carinii pneumonia (PCP, PJP)

1 yes

2 no

18. Other infection

1 yes →

19. Specify other infection: _____

2 no

History of Anti-Retroviral Therapy

20. Did the recipient receive anti-retroviral therapy prior to HSCT?

1 yes → **Continue with table below**

2 no → **Continue with question 124**

Therapy Given?	Date Started			Currently Receiving?	Therapy Stopped?	Date Stopped			Reason Stopped Code
	Month	Day	Year			Month	Day	Year	
21. Abacavir (Ziagen)	1 <input type="checkbox"/> yes →	22.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	23. 1 <input type="checkbox"/> yes	24. 1 <input type="checkbox"/> yes →	25.	<table border="1" style="width: 20px; height: 20px;"></table>	26. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
27. Atazanavir (Reyataz)	1 <input type="checkbox"/> yes →	28.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	29. 1 <input type="checkbox"/> yes	30. 1 <input type="checkbox"/> yes →	31.	<table border="1" style="width: 20px; height: 20px;"></table>	32. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
33. Didanosine (ddl, Videx)	1 <input type="checkbox"/> yes →	34.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	35. 1 <input type="checkbox"/> yes	36. 1 <input type="checkbox"/> yes →	37.	<table border="1" style="width: 20px; height: 20px;"></table>	38. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
39. Efavirenz (Sustiva)	1 <input type="checkbox"/> yes →	40.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	41. 1 <input type="checkbox"/> yes	42. 1 <input type="checkbox"/> yes →	43.	<table border="1" style="width: 20px; height: 20px;"></table>	44. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
45. Emtricitabine (Emtriva)	1 <input type="checkbox"/> yes →	46.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	47. 1 <input type="checkbox"/> yes	48. 1 <input type="checkbox"/> yes →	49.	<table border="1" style="width: 20px; height: 20px;"></table>	50. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
51. Fosamprenavir (Lexiva)	1 <input type="checkbox"/> yes →	52.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	53. 1 <input type="checkbox"/> yes	54. 1 <input type="checkbox"/> yes →	55.	<table border="1" style="width: 20px; height: 20px;"></table>	56. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
57. Indinavir (Crixivan)	1 <input type="checkbox"/> yes →	58.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	59. 1 <input type="checkbox"/> yes	60. 1 <input type="checkbox"/> yes →	61.	<table border="1" style="width: 20px; height: 20px;"></table>	62. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			
63. Lanuvudine (EpiVir, Epzicom, 3TC)	1 <input type="checkbox"/> yes →	64.	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	65. 1 <input type="checkbox"/> yes	66. 1 <input type="checkbox"/> yes →	67.	<table border="1" style="width: 20px; height: 20px;"></table>	68. <input type="checkbox"/>
	2 <input type="checkbox"/> no				2 <input type="checkbox"/> no	2 <input type="checkbox"/> no			

CIBMTR Form 2048 (HIV) 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			

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Therapy Given?	Date Started	Currently Receiving?	Therapy Stopped?	Date Stopped	Reason Stopped												
	Month Day Year			Month Day Year	Code												
69. Lopinavir / ritonavir (Kaletra) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	70. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							71. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	72. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	73. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							74. <input type="checkbox"/>
75. Nelfinavir (Viracept) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	76. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							77. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	78. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	79. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							80. <input type="checkbox"/>
81. Nevirapine (Viramune) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	82. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							83. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	85. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							86. <input type="checkbox"/>
87. Ritonavir (Norvir) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	88. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							89. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	91. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							92. <input type="checkbox"/>
93. Saquinavir (Fortovase, Invirase) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	94. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							95. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	96. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	97. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							98. <input type="checkbox"/>
99. Stavudine (Zerit, d4t) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	100. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							101. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	103. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							104. <input type="checkbox"/>
105. Tenofovir (Truvada, Viread) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	106. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	109. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							110. <input type="checkbox"/>
111. Zidovudine (Combivir, Retrovir, Trizivir, AZT) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	112. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							113. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	114. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	115. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							116. <input type="checkbox"/>
117. Other anti-retroviral therapy 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no	118. Specify other therapy: _____																
	119. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							120. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	121. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	122. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							123. <input type="checkbox"/>

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

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Initials:

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Today's Date:

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Infusion Date:

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Serological Evidence of HIV Exposure / Infection

Provide all documented CD4 counts 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 exponent:										
124. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	125. CD4 counts:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		x 10 <table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>	
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126. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	127. CD4 counts:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		x 10 <table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>	
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128. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	129. CD4 counts:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		x 10 <table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>	
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Provide all documented HIV 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:									
134. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	135. HIV viral load level:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		1 <input type="checkbox"/> copies/mL 2 <input type="checkbox"/> log ₁₀ /mL
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136. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	137. HIV viral load level:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		1 <input type="checkbox"/> copies/mL 2 <input type="checkbox"/> log ₁₀ /mL
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138. Date:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td>2</td></tr></table> <table border="1" style="width: 20px; height: 20px;"><tr><td>0</td></tr></table>	2	0	139. HIV viral load level:	<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		<table border="1" style="width: 20px; height: 20px;"><tr><td></td></tr></table>		1 <input type="checkbox"/> copies/mL 2 <input type="checkbox"/> log ₁₀ /mL
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144. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____