

CIBMTR Center Number:

CIBMTR Recipient ID:

Post-HSCT Planned Treatment for Lymphoma

6. Was planned treatment given per protocol since the date of the last report? (Include any maintenance therapy, but exclude any treatment for relapse / progressive disease.)

- 1 yes
- 2 no

Specify planned treatment given:

7. Chemotherapy
1 yes
2 no

8. Radiation
1 yes → Specify radiation site(s):
2 no

9. 1 yes 2 no mediastinum
10. 1 yes 2 no other site → 11. Specify site: _____

12. Immune therapy / monoclonal antibody (mAb)
1 yes → Specify therapy given:
2 no

13. 1 yes 2 no aldesleukin (interleukin-2, IL-2)
14. 1 yes 2 no alemtuzumab (Campath)
15. 1 yes 2 no rituximab (anti-CD20, Rituxan)
16. 1 yes 2 no other mAb → 17. Specify mAb: _____
18. 1 yes 2 no other immune therapy → 19. Specify therapy: _____

20. Other treatment
1 yes → 21. Specify planned treatment: _____
2 no

22. Was a disease relapse or progression detected by any method since the date of the last report?

- 1 yes
- 2 no

23. Specify the total number of nodal sites involved:
1 none
2 one nodal site
3 two or more nodal sites
4 unknown

24. Was there any known extranodal or splenic involvement since the date of the last report?
1 yes → Specify site(s) of involvement:
2 no

25. 1 yes 2 no Blood
26. 1 yes 2 no Bone
27. 1 yes 2 no Bone marrow
28. 1 yes 2 no Brain
29. 1 yes 2 no Cerebrospinal fluid (CSF)
30. 1 yes 2 no Epidural space
31. 1 yes 2 no Gastrointestinal (GI) tract
32. 1 yes 2 no Kidney
33. 1 yes 2 no Liver
34. 1 yes 2 no Lung
35. 1 yes 2 no Pleura
36. 1 yes 2 no Skin
37. 1 yes 2 no Spleen
38. 1 yes 2 no Other site → 39. Specify site: _____

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Specify the method(s) of disease assessment and results at the time of disease relapse or progression:

40. Molecular assessment

- 1 yes →
2 no

41. Date of molecular assessment:

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

42. Was disease detected?

- 1 yes
2 no

43. Cytogenetic assessment by FISH

- 1 yes →
2 no

44. Date of FISH assessment:

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

45. Was disease detected?

- 1 yes
2 no

46. Clinical / hematologic assessment

- 1 yes →
2 no

47. Date of clinical / hematologic assessment:

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

48. Was disease detected?

- 1 yes
2 no

49. Was a positron emission tomography (PET) scan performed since the date of the last report?

- 1 yes →
2 no

50. Date of most recent PET scan:

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

51. Results of most recent PET scan:

- 1 positive →
2 negative
3 indeterminate /
equivocal

52. Was the positive result considered a disease recurrence or progression?

- 1 yes
2 no

Disease Status at the Time of Assessment for This Reporting Period

53. Was the current disease status assessed by molecular testing?

- 1 yes →
2 no

54. Date of most recent molecular assessment:

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

55. Was disease detected?

- 1 yes
2 no

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56. Was the current disease status assessed by conventional cytogenetics / FISH?

- 1 yes
- 2 no

57. Date of most recent cytogenetic / FISH assessment:	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
58. Was disease detected?	Month	Day	Year
1 <input type="checkbox"/> yes			
2 <input type="checkbox"/> no			

59. What is the current disease status?

- 1 complete remission
- 2 not in complete remission

60. Date the current disease status was established in this reporting period:

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

61. Signed: _____
Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____