



**Fanconi Anemia /
Constitutional Anemia
Post-HSCT Data**

Registry Use Only

Sequence
Number:

Date
Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: / /
Month Day Year

Date of HSCT for which this form is
being completed: / /
Month Day Year

HSCT type: autologous allogeneic, allogeneic, syngeneic
unrelated related (identical twin)

Product type: marrow PBSC cord blood other product,
specify: _____

Visit: 100 day 6 month 1 year 2 years > 2 years,
specify: _____

To be completed in conjunction with a Form 2100 – 100 Days Post-HSCT Data, Form 2200 – Six Months to Two Years Post-HSCT Data, or Form 2300 – Yearly Follow-Up for Greater Than Two Years Post-HSCT Data. Information reported here should reflect the date of last contact as reported in the post-HSCT data collection form, or immediately prior to death.

Current Hematologic Parameters

1. Was the recipient red blood cell (RBC) transfusion independent since the date of the last report?

- 1 yes
- 2 no
- 3 unknown

2. Date of the most recent RBC transfusion: *

 / /
Month Day Year

* If the recipient was RBC transfusion independent for \geq one month but subsequently experienced a decline in RBCs and required transfusions, record the date of the last RBC transfusion before the decline. If the recipient has not required any transfusions since the initial date of recovery, record the date of the last RBC transfusion.

3. Was the recipient platelet transfusion independent since the date of the last report?

- 1 yes
- 2 no
- 3 unknown
- 4 not applicable / never dependent

4. Date of the most recent platelet transfusion: *

 / /
Month Day Year

* If the recipient was platelet transfusion independent for \geq 14 days but subsequently experienced a decline in platelets and required transfusions, record the date of the last platelet transfusion before the decline. If the recipient has not required any transfusions since the initial date of recovery, record the date of the last platelet transfusion.

5. Specify reticulocyte level (uncorrected):

- 1 known
- 2 not known / transfused

 . $10^9/L$

6. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

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