



## Multiple Sclerosis 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.**

1. Specify the date the recipient was evaluated for this report:          
Month Day Year

2. Did the MS recur or become exacerbated since the date of the last report?

- 1  yes  
2  no

3. Specify the date of recurrence or exacerbation:          
Month Day Year

4. Did the MS relapse since the date of the last report?

- 1  yes  
2  no

5. Specify the number of relapses since the date of the last report:    number unknown

## Treatment for Multiple Sclerosis

6. Did the recipient receive any treatment for MS since the date of the last report?

- 1  yes → **Continue with table below**  
2  no → **Continue with question 78**  
3  unknown →

Therapy Given?	Reason for Therapy Code	Date Therapy Started	Currently Receiving?	
		Month Day Year		
7. $\alpha$ -interferon 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	8. <input type="text"/>	9. If Code 4 — Other reason, specify: _____	10. <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	11. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
12. $\beta$ -interferon 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	13. <input type="text"/>	14. If Code 4 — Other reason, specify: _____	15. <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	16. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

### Reason for Therapy Codes

1 Planned per protocol   2 Continued from prior to HSCT   3 Relapse / progression of MS   4 Other reason   5 Reason unknown

CIBMTR Center Number:

CIBMTR Recipient ID:

Therapy Given?	Reason for Therapy Code	Date Therapy Started			Currently Receiving?	
		Month	Day	Year		
17. Anti-lymphocyte antibodies 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	18. <input type="text"/>	19. If Code 4 — Other reason, specify: _____	20. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	21. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
22. Azathioprine 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	23. <input type="text"/>	24. If Code 4 — Other reason, specify: _____	25. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	26. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
27. Cop-I 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	28. <input type="text"/>	29. If Code 4 — Other reason, specify: _____	30. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
32. Corticosteroids — chronic low-dose 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	33. <input type="text"/>	34. If Code 4 — Other reason, specify: _____	35. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
37. Corticosteroids — pulse high-dose 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	38. <input type="text"/>	39. If Code 4 — Other reason, specify: _____	40. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
42. Craniospinal irradiation 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	43. <input type="text"/>	44. If Code 4 — Other reason, specify: _____	45. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
47. Cyclophosphamide 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	48. <input type="text"/>	49. If Code 4 — Other reason, specify: _____	50. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
52. Lymphocytopheresis 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	53. <input type="text"/>	54. If Code 4 — Other reason, specify: _____	55. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
57. Mitoxantrone 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	58. <input type="text"/>	59. If Code 4 — Other reason, specify: _____	60. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
62. Plasmapheresis 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	63. <input type="text"/>	64. If Code 4 — Other reason, specify: _____	65. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	66. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
67. Total lymph node irradiation (TLI) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	68. <input type="text"/>	69. If Code 4 — Other reason, specify: _____	70. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	71. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	
72. Other treatment 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	73. Specify other treatment: _____	74. <input type="text"/>	75. If Code 4 — Other reason, specify: _____	76. <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>2 0</b> <input type="text"/> <input type="text"/>	77. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

**Reason for Therapy Codes**

1 Planned per protocol    2 Continued from prior to HSCT    3 Relapse / progression of MS    4 Other reason    5 Reason unknown

CIBMTR Center Number:

CIBMTR Recipient ID:

### Disease Status at Current Evaluation

78. Was the Scripps neurological rating scale performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

79. Specify the Scripps scale score:   Scripps scale score unknown

80. Was the Kurtze functional systems scale performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

Specify the following Scripps Kurtze functional systems scale scores:

- 81. Pyramidal:   scale score unknown
- 82. Cerebellar:   scale score unknown
- 83. Brain stem:   scale score unknown
- 84. Sensory:   scale score unknown
- 85. Bowel / bladder:   scale score unknown
- 86. Visual:   scale score unknown
- 87. Cerebral:   scale score unknown
- 88. Other function:  89. Specify other function: \_\_\_\_\_  scale score unknown

90. Was the Kurtze Expanded Disability Status Scale (EDSS) performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

91. Specify the Kurtze EDSS score:  .   Kurtze EDSS score unknown

92. Was a timed 25-foot walk performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

93. Was an assistive device used?

- 1  yes
- 2  no

94. Specify assistive device:

- 1  unilateral assistance (cane or crutch)
- 2  bilateral assistance (canes or crutches)
- 3  walker or similar device

95. Time for Trial 1:  .  seconds 1  did not complete walk 2  time unknown

96. Time for Trial 2:  .  seconds 1  did not complete walk 2  time unknown

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97. Was a 9-hole peg test performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

Specify the time trial results for the recipient's dominant hand:

98. Time for Trial 1:    .  seconds 1  did not complete trial 2  time unknown

99. Time for Trial 2:    .  seconds 1  did not complete trial 2  time unknown

Specify the time trial results for the recipient's non-dominant hand:

100. Time for Trial 1:    .  seconds 1  did not complete trial 2  time unknown

101. Time for Trial 2:    .  seconds 1  did not complete trial 2  time unknown

102. Was a Paced Auditory Serial Addition Test (PASAT) performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

103. Specify the PASAT 3 score:   range (0-60)  score unknown

104. Specify the PASAT 2 score:   range (0-60)  score unknown

105. Was a MRI scan of the brain performed since the date of the last report?

- 1  yes
- 2  no
- 3  unknown

106. Date of most recent MRI:            date unknown  
Month Day Year

107. Are gadolinium-enhancing lesions present on the MRI?

- 1  yes
- 2  no
- 3  unknown

108. Specify number of lesions:    number unknown

109. Are any new lesions present on the MRI?

- 1  yes
- 2  no
- 3  unknown

110. Specify the new lesions present:

- 1  gadolinium-enhancing
- 2  unenhancing
- 3  both
- 4  unknown

111. Was there evidence of disease activity present at the current evaluation?

- 1  yes
- 2  no
- 3  unknown

112. Specify the date of first evidence of disease activity at the current evaluation:            date unknown  
Month Day Year

113. Signed: \_\_\_\_\_

*Person completing form*

Please print name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_