

ERROR CORRECTION FORM

Sequence Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Initials:

--	--

Today's Date:

Month	Day	Year																	

Infusion Date:

Month	Day	Year																	

CIBMTR Center Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--



Breast Cancer 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, unrelated allogeneic, related syngeneic (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.

Questions followed by the symbol indicate additional information necessary to complete the question is referenced in the forms instruction manual.

Disease Assessment at the Time of Best Response to HSCT

Best response is based on response to the HSCT, but does NOT include response to any therapy given for disease relapse or progression post-HSCT. When determining the best response to HSCT, compare the post-HSCT disease status to the status immediately prior to the preparative regimen, regardless of time since HSCT. This comparison is meant to capture the BEST disease status in response to HSCT that occurred in the reporting interval, even if a subsequent disease relapse or progression occurred during the same reporting interval. If a recipient already achieved their best response in a previous reporting interval, confirm the best response and check the box to indicate "date previously reported."

1. Compared to the disease status prior to the preparative regimen, what was the best response to HSCT since the date of the last report? (Include response to any post-HSCT treatment planned as of Day 0.) (see definitions on page 3)

- 1 CR
- 2 CRU
- 3 PR
- 4 SD
- 5 PD
- 6 NA
- 7 not evaluable, toxic death

2. Date the best response first began:

Month	Day	Year																	

date previously reported

3. Did the recipient experience any disease progression post-HSCT?

- 1 yes
- 2 no
- 3 unknown

4. Date of progression / relapse:

Month	Day	Year																	

date unknown

5. Was there subsequent disease stability or regression without further therapy (so-called graft-versus-tumor effect)?

- 1 yes
- 2 no
- 3 unknown

6. Did this change in disease status qualify as a partial response or better if compared to a post-HSCT imaging study? (see page 3 for criteria to define partial response)

- 1 yes
- 2 no

7. Date of response:

Month	Day	Year																	

date unknown date previously reported

ERROR CORRECTION FORM

Sequence Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Initials:

--

Today's Date:

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

Infusion Date:

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

CIBMTR Center Number:

--	--	--	--	--	--	--	--	--	--

CIBMTR Center Number:

CIBMTR Recipient ID:

Post-HSCT Treatment for Breast Cancer

8. Was therapy given for breast cancer since the date of the last report?

- 1 yes →
2 no

	1st Line of Therapy	2nd Line of Therapy																
Was post-HSCT therapy planned as of Day 0?	9. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	69. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
Systemic Therapy:	10. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 47	70. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 107																
Date therapy started:	11. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Day</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>					Month	Day	Year	Year	71. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Day</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>					Month	Day	Year	Year
Month	Day	Year	Year															
Month	Day	Year	Year															
Number of cycles:	12. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> <input type="checkbox"/> unknown/not applicable			72. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> <input type="checkbox"/> unknown/not applicable														
Was therapy given prior to any surgery (neoadjuvant)?	13. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	73. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
5-fluorouracil (5-FU, Adrucil)	14. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	74. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
anastrozole (Arimidex)	15. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	75. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
bevacizumab (Avastin)	16. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	76. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
capecitabine (Xeloda)	17. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	77. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
cisplatin (Platinol, CDDP)	18. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	78. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
cyclophosphamide (CTX)	19. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	79. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
daunorubicin (Cerubidine)	20. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	80. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
daunorubicin liposomal	21. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	81. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
docetaxel (Taxotere)	22. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	82. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
doxorubicin (Adriamycin)	23. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	83. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
doxorubicin liposomal (Doxil)	24. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
epirubicin (Ellence)	25. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	85. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
exemestane (Aromasin)	26. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	86. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
gemcitabine (Gemzar)	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	87. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
goserelin acetate (Zoladex)	28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	88. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
idarubicin (Idamycin)	29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	89. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
lapatinib (Tykerb)	30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
letrozole (Femara)	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	91. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
megestrol (Megace)	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	92. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
methotrexate (MTX, Folex)	33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	93. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
mitoxantrone (Novantrone)	34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
paclitaxel (Abraxane, Taxol)	35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	95. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
pamidronate (Aredia)	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	96. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
tamoxifen (Nolvadex)	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	97. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
thiotepa (Thioplex)	38. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
toremifene (Fareston)	39. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
trastuzumab (Herceptin)	40. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 42	100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 102																
specify number of doses	41. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table>			101. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table>														
vinorelbine (Velban)	42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
vinorelbine (Navelbine)	43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
zoledronic acid (Zometa)	44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
other systemic therapy	45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
specify other therapy	46. _____	106. _____																
Radiation Therapy:	47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 54	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 114																
Date therapy started:	48. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Day</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>					Month	Day	Year	Year	108. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr><tr><td style="font-size: 8px; text-align: center;">Month</td><td style="font-size: 8px; text-align: center;">Day</td><td style="font-size: 8px; text-align: center;">Year</td><td style="font-size: 8px; text-align: center;">Year</td></tr></table>					Month	Day	Year	Year
Month	Day	Year	Year															
Month	Day	Year	Year															
Local / regional	49. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 51	109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 111																
Specify total dose:	50. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> cGy (rads)					110. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> cGy (rads)												
Other radiotherapy site	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 54	111. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 114																
Specify other radiation site:	52. _____	112. _____																
Specify total dose:	53. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> cGy (rads)					113. <table style="display: inline-table; border-collapse: collapse;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table> cGy (rads)												

ERROR CORRECTION FORM

Sequence Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Initials:

--

Today's Date:

		2	0		
Month	Day	Year			

Infusion Date:

		2	0		
Month	Day	Year			

CIBMTR Center Number:

--	--	--	--	--	--	--	--

CIBMTR Center Number:

--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

<p>Surgery (not biopsy): 54. <input type="checkbox"/> yes <input type="checkbox"/> no → cont. with q. 60</p> <p>Date of surgery: 55. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>lumpectomy 56. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>mastectomy 57. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>other surgery 58. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>specify other surgery 59. _____</p> <p>Was recipient on a study? 60. <input type="checkbox"/> yes <input type="checkbox"/> no → cont. with q. 62</p> <p>specify study: 61. _____</p> <p>Best Response to Line of Therapy: (see definitions below)</p> <p>If non-bone code is "1" was the complete response pathologically confirmed?</p> <p>Date response established: 63. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>Did disease relapse/progress following this line of therapy? 64. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Date of relapse/progression: 65. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>Specify site(s) of relapse/progression: 66. _____</p>							Month	Day	Year										Month	Day	Year										Month	Day	Year				<p>114. <input type="checkbox"/> yes <input type="checkbox"/> no → cont. with q. 120</p> <p>115. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>116. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>117. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>118. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>119. _____</p> <p>120. <input type="checkbox"/> yes <input type="checkbox"/> no → cont. with q. 122</p> <p>121. _____</p> <table style="width: 100%;"> <tr> <td style="width: 33%;">62. Non-Bone Response Code (see codes below)</td> <td style="width: 33%;">64. Bone Response Code (see codes below)</td> <td style="width: 33%;">122. Non-Bone Response Code (see codes below)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>123. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>124. Bone Response Code (see codes below)</p> <p style="text-align: center;"><input type="checkbox"/></p> <p>125. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>126. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>127. <table border="1" style="display: inline-table; width: 100px; height: 20px;"><tr><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td></td><td></td><td></td></tr></table></p> <p>128. _____</p> <p style="text-align: center;">Copy this page to report more than 2 lines of therapy; check here <input type="checkbox"/> if additional pages are attached.</p>							Month	Day	Year				62. Non-Bone Response Code (see codes below)	64. Bone Response Code (see codes below)	122. Non-Bone Response Code (see codes below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							Month	Day	Year										Month	Day	Year			
Month	Day	Year																																																																													
Month	Day	Year																																																																													
Month	Day	Year																																																																													
Month	Day	Year																																																																													
62. Non-Bone Response Code (see codes below)	64. Bone Response Code (see codes below)	122. Non-Bone Response Code (see codes below)																																																																													
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																													
Month	Day	Year																																																																													
Month	Day	Year																																																																													

Non-Bone Best Response Codes — Response Evaluation Criteria in Solid Tumors (RECIST)

- 1 complete response (CR) — disappearance of all target lesions for a period of at least one month
- 2 complete response with persistent imaging abnormalities of unknown significance (CRU)
- 3 partial response (PR) — at least 30% decrease in the sum of the longest diameter of measured lesions (target lesions) taking as reference the baseline sum of longest diameters
- 4 stable disease (SD) — neither sufficient shrinkage to qualify for PR nor sufficient increase to qualify for PD, taking as reference the smallest sum of the longest diameters since the treatment started
- 5 progressive disease (PD) — at least a 20% increase in the sum of the longest diameter of measured lesions (target lesions), taking as reference the smallest sum of the longest diameters recorded since the treatment started or the appearance of one or more new lesions
- 6 not assessed (NA)
- 7 not evaluable, toxic death (NETD)

Bone Best Response Codes

- 1 no prior bone disease
- 2 symptomatic improvement, no progression
- 3 symptomatic and radiographic (not bone scan only) improvement
- 4 no response
- 5 progressive disease
- 6 not assessed / radiographic data not available

ERROR CORRECTION FORM

Sequence Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Initials:

--	--

Today's Date:

		2	0		
Month	Day	Year			

Infusion Date:

				2	0		
Month	Day	Year					

CIBMTR Center Number:

--	--	--	--	--	--	--	--

CIBMTR Center Number:

--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Disease Status at the Time of Assessment for this Reporting Period

129. What was the current disease status?

- 1 complete remission
2 not in complete remission

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

				2	0		
Month	Day	Year					

131. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____