

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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Ovarian Cancer Post-HSCT Data

Registry Use Only

Sequence Number:

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Date Received:

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CIBMTR Recipient ID:

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Today's Date:

				2	0		
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:

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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.)

- 1 CR
- 2 CRU
- 3 PR
- 4 SD
- 5 PD
- 6 NA
- 7 NETD

2. Date the best response first began:

				2	0		
Month	Day	Year					

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)

CIBMTR Form 2123 (OV) v1.0 (1–4) July 2007
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Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

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CIBMTR Center Number:

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Post-HSCT Treatment for Ovarian Cancer

21. Was therapy given since the date of the last report?

- 1 yes →
2 no

Line of Therapy:	1st Line of Therapy	2nd Line of Therapy																
Was post-HSCT therapy planned as of Day 0?	22. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
Systemic Therapy:	23. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 65	85. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 127																
Date therapy started:	24. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year		86. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year	
Month	Day	Year																
Month	Day	Year																
Date therapy stopped:	25. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year		87. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year	
Month	Day	Year																
Month	Day	Year																
Number of cycles:	26. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> <input type="checkbox"/> unknown/not applicable	88. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> <input type="checkbox"/> unknown/not applicable																
aldesleukin (interleukin-2)	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	89. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
altretamine (Hexalen)	28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
anastrozole (Arimidex)	29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	91. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
bevacizumab (Avastin)	30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	92. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
capecitabine (Xeloda)	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	93. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
carboplatin (Paraplatin)	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
cisplatin (CDDP, Platinol)	33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	95. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
cyclophosphamide (CTX)	34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	96. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
cytarabine (Ara-C, Cytosar-U)	35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	97. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
docetaxel (Taxotere)	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
doxorubicin (Adriamycin)	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
doxorubicin liposomal (Doxil)	38. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
epirubicin (Ellence)	39. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	101. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
erlotinib (Tarceva)	40. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
etoposide (VP-16, VePesid)	41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
exemestane (Aromasin)	42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
fluorouracil (5-FU, Adrucil)	43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
fulvestrant (Faslodex)	44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
gemcitabine (Gemzar)	45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
ifosfamide (Ifex)	46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
imatinib (Gleevec)	47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
interferon-α (Roferon-α)	48. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	110. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
irinotecan (Camptosar)	49. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	111. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
lapatinib (Tykerb)	50. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	112. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
letrozole (Femara)	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	113. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
mitoxantrone (Novantrone)	52. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	114. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
oxaliplatin (Eloxatin)	53. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	115. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
paclitaxel (Taxol)	54. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	116. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
prednisone (Sterapred)	55. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	117. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
sorafenib (Bayer)	56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	118. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
sunitinib (Sutent, SU11248)	57. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	119. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
tamoxifen (Nolvadex)	58. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	120. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
thiotepa (Thioplex)	59. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	121. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
topotecan (Hycamtin)	60. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	122. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
vinblastine (Velban, VLB)	61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	123. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
vinorelbine (Navelbine)	62. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	124. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
other therapy	63. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	125. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no																
specify other therapy	64. _____	126. _____																
Radiation Therapy:	65. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 75	127. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 141																
Date therapy started:	66. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year		128. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year	
Month	Day	Year																
Month	Day	Year																
Date therapy stopped:	67. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year		129. <table border="1" style="width: 100%; text-align: center;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td colspan="2">Year</td></tr></table>					Month	Day	Year	
Month	Day	Year																
Month	Day	Year																
Local / regional	68. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 70	130. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 132																
Specify total dose	69. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> cGy (rads)	131. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> cGy (rads)																
Sites of non-contiguous extra-abdominal metastases	70. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 73	132. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 134																
Specify total dose	71. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> cGy (rads)	133. <table border="1" style="width: 40px; height: 20px; text-align: center;"> </table> cGy (rads)																

CIBMTR Form 2123 (OV) v1.0 (3-4) July 2007
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Sequence Number:

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Initials:

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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:

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CIBMTR Center Number:

CIBMTR Recipient ID:

<p>Other radiotherapy site Specify other radiation site 72. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 75</p> <p>Specify total dose 73. _____</p> <p>74. <table border="1" style="width: 40px; height: 20px;"></table> cGy (rads)</p> <p>Abdominal Surgery: 75. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 79</p> <p>Date of surgery: 76. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>Type of abdominal surgery (see options at question 4) 77. <table border="1" style="width: 20px; height: 20px;"></table></p> <p>Specify surgery (option 8) 78. _____</p> <p>Best Response to Line of Therapy: (see definitions on page 1)</p> <p>79. 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> CRU 3 <input type="checkbox"/> PR 4 <input type="checkbox"/> SD 5 <input type="checkbox"/> PD 6 <input type="checkbox"/> NA 7 <input type="checkbox"/> NETD 8 <input type="checkbox"/> unknown / not tested</p> <p>Date response evaluated: 80. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>Did patient relapse/progress following this line of therapy? 81. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no</p> <p>Date of relapse/progression: 82. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>Specify site(s) of relapse: 83. _____</p>				Month	Day	Year				Month	Day	Year				Month	Day	Year	<p>134. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 137</p> <p>135. _____</p> <p>136. <table border="1" style="width: 40px; height: 20px;"></table> cGy (rads)</p> <p>137. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 141</p> <p>138. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>139. <table border="1" style="width: 20px; height: 20px;"></table></p> <p>140. _____</p> <p>141. 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> CRU 3 <input type="checkbox"/> PR 4 <input type="checkbox"/> SD 5 <input type="checkbox"/> PD 6 <input type="checkbox"/> NA 7 <input type="checkbox"/> NETD 8 <input type="checkbox"/> unknown / not tested</p> <p>142. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>143. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no</p> <p>144. <table style="display: inline-table; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 20px; height: 20px; border: 1px solid black;"></td><td style="width: 40px; height: 20px; border: 1px solid black;"></td></tr> <tr><td style="text-align: center;">Month</td><td style="text-align: center;">Day</td><td style="text-align: center;">Year</td></tr> </table></p> <p>145. _____</p>				Month	Day	Year				Month	Day	Year				Month	Day	Year
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Month	Day	Year																																			
Month	Day	Year																																			
Month	Day	Year																																			
Month	Day	Year																																			

Copy this page to report more than 2 lines of therapy; check here if additional pages are attached.

Disease Status at the Time of Assessment for This Reporting Period

Specify imaging performed:	Specify imaging method:	Specify results:	Was tumor present?
	yes no	normal abnormal	
146. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Bone imaging →	147. 1 <input type="checkbox"/> 2 <input type="checkbox"/> Bone scan →	148. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	149. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
150. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT →	151. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT →	152. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	153. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
153. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no MRI →	154. 1 <input type="checkbox"/> 2 <input type="checkbox"/> MRI →	155. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	156. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
156. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no X-ray →	157. 1 <input type="checkbox"/> 2 <input type="checkbox"/> X-ray →	158. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	159. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
159. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Chest x-ray →	160. 1 <input type="checkbox"/> 2 <input type="checkbox"/> Chest x-ray →	161. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	162. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
162. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of chest →	163. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT scan of chest →	164. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	165. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
165. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of abdomen →	166. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT scan of abdomen →	167. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	168. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
168. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of pelvis →	169. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT scan of pelvis →	170. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	171. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
171. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Head imaging →	172. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT →	173. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	174. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
	175. 1 <input type="checkbox"/> 2 <input type="checkbox"/> MRI →	176. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	177. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
178. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no PET scan →	179. 1 <input type="checkbox"/> 2 <input type="checkbox"/> PET scan →	180. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	181. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk

181. What is the current disease status?

- 1 complete remission
- 2 not in complete remission

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

		20
Month	Day	Year

183. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____