

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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Sarcoma Post-HSCT Data

Registry Use Only

Sequence Number:

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Date Received:

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CIBMTR Center Number:

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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: _____

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.

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 planned post-HSCT treatment.) (see below for descriptions of response codes)

- 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					

date of the best response previously reported

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 2124 (SAR) 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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Best Response to Line of Therapy: (see definitions on page 1)
58. 1 CR 2 CRU 3 PR 4 SD 5 PD 6 NA 7 NETD
99. 1 CR 2 CRU 3 PR 4 SD 5 PD 6 NA 7 NETD

Date response evaluated: 59.

Month	Day	Year	

 100.

Month	Day	Year	

Did disease relapse/progress following this line of therapy? 60. 1 yes 2 no 101. 1 yes 2 no

Date of relapse/progression: 61.

Month	Day	Year	

 102.

Month	Day	Year	

Specify site(s) of relapse: 62. _____ 103. _____

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

104. What is the current disease status?

- 1 complete remission
- 2 not in complete remission

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

		2	0		
Month	Day	Year			

106. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____