

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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Congenital Amegakaryocytic Thrombocytopenia Post-HSCT Data

Registry Use Only

Sequence Number:

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Date Received:

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

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.

1. What was the date of the last platelet transfusion since the date of the last report?

Month	Day	Year			

2. What was the date of the last red blood cell transfusion since the date of the last report?

Month	Day	Year			

3. Was the bone marrow examined since the date of the last report?

1 yes →
2 no

4. Specify the most recent date the bone marrow was examined:

Month	Day	Year			

5. What was the cellularity of the bone marrow?

- 1 decreased
- 2 normal
- 3 increased

6. What was the megakaryocyte level in the bone marrow?

- 1 decreased
- 2 absent

7. Were myelodysplastic features present?

- 1 yes →
- 2 no

8. Specify the level of blasts in the marrow: _____ %

9. Is a copy of the bone marrow report attached?

- 1 yes
- 2 no

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

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Initials:

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Today's Date:

Month	Day	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year

Infusion Date:

Month	Day	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year	Year

CIBMTR Center Number:

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10. Was a bone marrow karyotype examination performed since the date of the last report?

- 1 yes
2 no
3 unknown

11. Were any karyotype abnormalities identified?

- 1 yes
2 no

Specify the abnormalities identified:

12. 1 yes 2 no -5
13. 1 yes 2 no -7
14. 1 yes 2 no -17
15. 1 yes 2 no -18
16. 1 yes 2 no -20
17. 1 yes 2 no -X
18. 1 yes 2 no -Y
19. 1 yes 2 no +4
20. 1 yes 2 no +8
21. 1 yes 2 no +11
22. 1 yes 2 no +13
23. 1 yes 2 no +14
24. 1 yes 2 no +21
25. 1 yes 2 no +22
26. 1 yes 2 no del(5q) / 5q-
27. 1 yes 2 no del(7q) / 7q-
28. 1 yes 2 no del(9q) / 9q-
29. 1 yes 2 no del(11q) / 11q-
30. 1 yes 2 no del(17q) / 17q-
31. 1 yes 2 no del(20q) / 20q-
32. 1 yes 2 no inv(3)
33. 1 yes 2 no inv(16)
34. 1 yes 2 no t(3;3)
35. 1 yes 2 no t(6;9)
36. 1 yes 2 no t(8;21)
37. 1 yes 2 no t(15;17) and variants
38. 1 yes 2 no (11q23) balanced abnormality
39. 1 yes 2 no 12p any abnormality
40. 1 yes 2 no complex (≥ 3 distinct abnormalities)
41. 1 yes 2 no other abnormality,
42. Specify: _____

43. Is a copy of the cytogenetic report attached?

- 1 yes
2 no

44. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____ Fax: (_____) _____

E-mail address: _____

CIBMTR Form 2135 (CAT) v1.0 (2-2) July 2007
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Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).