

# 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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## Hemophagocytic Lymphohistiocytosis 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  multiple cord blood units infused  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.**

Specify the recipient's clinical status since the date of the last report:

- |  |                                    |                                   |                                    |
|--|------------------------------------|-----------------------------------|------------------------------------|
| 1. Hepatomegaly (> 3 cm below right costal margin) | 1 <input type="checkbox"/> present | 2 <input type="checkbox"/> absent | 3 <input type="checkbox"/> unknown |
| 2. Hypertriglyceridemia (> 200 mg/dL)              | 1 <input type="checkbox"/> present | 2 <input type="checkbox"/> absent | 3 <input type="checkbox"/> unknown |
| 3. Hypofibrinogenemia (< 150 mg/dL)                | 1 <input type="checkbox"/> present | 2 <input type="checkbox"/> absent | 3 <input type="checkbox"/> unknown |
| 4. Splenomegaly (> 3 cm below left costal margin)  | 1 <input type="checkbox"/> present | 2 <input type="checkbox"/> absent | 3 <input type="checkbox"/> unknown |

Specify the recipient's cerebrospinal fluid findings since the date of the last report:

- |                    |   |   |                                       |
|--------------------|---|---|---------------------------------------|
| 5. Neopterin level | 1 <input type="checkbox"/> normal       | 2 <input type="checkbox"/> elevated     | 3 <input type="checkbox"/> not tested |
| 6. Protein         | 1 <input type="checkbox"/> normal       | 2 <input type="checkbox"/> elevated     | 3 <input type="checkbox"/> not tested |
| 7. WBC count       | 1 <input type="checkbox"/> ≤ 5 cells/μl | 2 <input type="checkbox"/> > 5 cells/μl | 3 <input type="checkbox"/> not tested |

8. What is the recipient's clinical neurologic status since the date of the last report?

- 1  normal  
 2  abnormal →  
 3  unknown

	Improvement in Pre-HSCT Abnormalities	Stable Pre-HSCT Abnormalities	Deterioration of Pre-HSCT Abnormalities	Abnormalities Developed Post-HSCT
Abnormal gait	9. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	10. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	11. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	12. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Developmental delay	13. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	14. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	15. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	16. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Mental retardation	17. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	18. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	19. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	20. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Motor weakness	21. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	22. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	23. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	24. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Seizures	25. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	26. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Sensory deficits	29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Other dysfunction	33. Specify other dysfunction: _____			
	34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

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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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38. Was an MRI or CT performed since the date of the last report?

- 1  yes  
2  no

39. Specify results:

- 1  improvement in pre-HSCT abnormalities  
2  stable pre-HSCT abnormalities  
3  worsening of pre-HSCT abnormalities

40. Is a copy of the report attached?

- 1  yes  
2  no

41. Was the clinical status of natural killer cell activity assessed since the date of the last report? (*refers to specific cytolysis of NK-sensitive target cells, e.g. K562*)

- 1  yes  
2  no

42. Specify the current natural killer cell function:

- 1  absent ( $\leq 10\%$  normal response)  
2  decreased (11–60% normal response)  
3  normal  
4  increased  
5  unknown

43. Signed: \_\_\_\_\_

*Person completing form*

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

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

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

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