

# ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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Initials:

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Today's Date:

		20		
Month	Day	Year		

Infusion Date:

		20		
Month	Day	Year		

CIBMTR Center Number:

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## Langerhans Cell Histiocytosis 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:

		20		
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 best response to HSCT, excluding any planned post-HSCT therapy, since the date of the last report?
- 1  complete response — absence of all signs and/or symptoms of Langerhans cell histiocytosis
  - 2  partial response — regression of signs and/or symptoms of disease without appearance of new lesions
  - 3  stable disease — persistence of signs and/or symptoms of disease without appearance of new lesions
  - 4  mixed response — regression of some signs and/or symptoms of disease with appearance of new lesions
  - 5  progressive disease — progression of signs and/or symptoms of disease initially detected and/or reappearance of old and/or appearance of new lesions
  - 6  unknown
  - 7  not evaluable → 2. Specify reason: \_\_\_\_\_

3. Specify the date best response was determined: \_\_\_\_\_
- Month      Day      Year

4. Did the disease recur or progress since the date of the last report?
- 1  yes →
  - 2  no
  - 3  unknown
- Specify the organ(s) involved in the disease recurrence or progression:

  - 5. 1  yes 2  no 3  unknown Bone
  - 6. 1  yes 2  no 3  unknown Bone marrow
  - 7. 1  yes 2  no 3  unknown Central nervous system
  - 8. 1  yes 2  no 3  unknown Gastrointestinal tract
  - 9. 1  yes 2  no 3  unknown Liver
  - 10. 1  yes 2  no 3  unknown Lung
  - 11. 1  yes 2  no 3  unknown Lymph nodes
  - 12. 1  yes 2  no 3  unknown Skin
  - 13. 1  yes 2  no 3  unknown Spleen
  - 14. 1  yes 2  no 3  unknown Other organ → 15. Specify: \_\_\_\_\_

16. Specify the date disease recurrence or progression was determined: \_\_\_\_\_

Month      Day      Year

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



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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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CIBMTR Center Number:

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CIBMTR Recipient ID:

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51. What is the current status of Langerhans cell histiocytosis? (For recipients who died since the date of the last report, report the disease status at the time of death.)

- 1  complete response — absence of all signs and/or symptoms of Langerhans cell histiocytosis
- 2  partial response — regression of signs and/or symptoms of disease without appearance of new lesions
- 3  stable disease — persistence of signs and/or symptoms of disease without appearance of new lesions
- 4  mixed response — regression of some signs and/or symptoms of disease with appearance of new lesions
- 5  progressive disease — progression of signs and/or symptoms of disease initially detected and/or reappearance of old and/or appearance of new lesions
- 6  unknown
- 7  not evaluable →

52. Specify reason: \_\_\_\_\_

53. Specify the date the current disease status was determined:

				2	0		
Month	Day	Year					

54. Signed: \_\_\_\_\_  
*Person completing form*

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

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

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

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