

ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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

Initials:

--	--

Today's Date:

		2	0		
Month	Day	Year	Year		

Infusion Date:

		2	0		
Month	Day	Year	Year		

CIBMTR Center Number:

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Multiple Sclerosis 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:

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

Today's Date:

		2	0		
Month	Day	Year	Year		

Date of HSCT for which this form is being completed:

Month	Day	Year	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. Specify the date the recipient was evaluated for this report: _____

2. Did the MS recur or become exacerbated since the date of the last report?

- 1 yes
2 no

3. Specify the date of recurrence or exacerbation: _____

4. Did the MS relapse since the date of the last report?

- 1 yes
2 no

5. Specify the number of relapses since the date of the last report: _____ number unknown

Treatment for Multiple Sclerosis

6. Did the recipient receive any treatment for MS since the date of the last report?

- 1 yes → Continue with table below
2 no → Continue with question 78
3 unknown → Continue with question 78

Therapy Given?	Reason for Therapy Code	Date Therapy Started	Currently Receiving?						
	Code	Month Day Year							
7. α-interferon	8. <input type="checkbox"/>	9. If Code 4 — Other reason, specify: _____	11. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no						
1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown		10. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr></table>			2	0			
		2	0						
12. β-interferon	13. <input type="checkbox"/>	14. If Code 4 — Other reason, specify: _____	16. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no						
1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown		15. <table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr></table>			2	0			
		2	0						

Reason for Therapy Codes

- 1 Planned per protocol 2 Continued from prior to HSCT 3 Relapse / progression of MS 4 Other reason 5 Reason unknown

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Sequence Number:

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Initials:

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

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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Therapy Given?	Reason for Therapy Code	Date Therapy Started	Currently Receiving?
		Month Day Year	
17. Anti-lymphocyte antibodies 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	17. <input type="checkbox"/> 19. If Code 4 — Other reason, specify: _____	20. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	21. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
22. Azathioprine 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	22. <input type="checkbox"/> 24. If Code 4 — Other reason, specify: _____	23. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	26. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
27. Cop-I 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	27. <input type="checkbox"/> 29. If Code 4 — Other reason, specify: _____	28. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
32. Corticosteroids — chronic low-dose 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	32. <input type="checkbox"/> 34. If Code 4 — Other reason, specify: _____	33. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
37. Corticosteroids — pulse high-dose 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	37. <input type="checkbox"/> 39. If Code 4 — Other reason, specify: _____	38. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
42. Craniospinal irradiation 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	42. <input type="checkbox"/> 44. If Code 4 — Other reason, specify: _____	43. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
47. Cyclophosphamide 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	47. <input type="checkbox"/> 49. If Code 4 — Other reason, specify: _____	48. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
52. Lymphocytapheresis 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	52. <input type="checkbox"/> 54. If Code 4 — Other reason, specify: _____	53. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
57. Mitoxantrone 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	57. <input type="checkbox"/> 59. If Code 4 — Other reason, specify: _____	58. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
62. Plasmapheresis 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	62. <input type="checkbox"/> 64. If Code 4 — Other reason, specify: _____	63. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	66. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
67. Total lymph node irradiation (TLI) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	67. <input type="checkbox"/> 69. If Code 4 — Other reason, specify: _____	68. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	71. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
72. Other treatment 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	72. Specify other treatment: _____ 73. <input type="checkbox"/> 75. If Code 4 — Other reason, specify: _____	74. <input type="checkbox"/> <input type="checkbox"/> 20 <input type="checkbox"/> <input type="checkbox"/>	77. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

Reason for Therapy Codes

1 Planned per protocol 2 Continued from prior to HSCT 3 Relapse / progression of MS 4 Other reason 5 Reason unknown

CIBMTR Form 2143 (MS) v1.0 (2-4) July 2007
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Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

ERROR CORRECTION FORM

Sequence Number:

CIBMTR Recipient ID:

Initials:

Today's Date:

Month Day Year

Infusion Date:

Month Day Year

CIBMTR Center Number:

CIBMTR Center Number:

CIBMTR Recipient ID:

97. Was a 9-hole peg test performed since the date of the last report?

- 1 yes
2 no
3 unknown

Specify the time trial results for the recipient's dominant hand:

98. Time for Trial 1: . seconds 1 did not complete trial 2 time unknown

99. Time for Trial 2: . seconds 1 did not complete trial 2 time unknown

Specify the time trial results for the recipient's non-dominant hand:

100. Time for Trial 1: . seconds 1 did not complete trial 2 time unknown

101. Time for Trial 2: . seconds 1 did not complete trial 2 time unknown

102. Was a Paced Auditory Serial Addition Test (PASAT) performed since the date of the last report?

- 1 yes
2 no
3 unknown

103. Specify the PASAT 3 score: range (0-60) score unknown

104. Specify the PASAT 2 score: range (0-60) score unknown

105. Was a MRI scan of the brain performed since the date of the last report?

- 1 yes
2 no
3 unknown

106. Date of most recent MRI:
Month Day Year date unknown

107. Are gadolinium-enhancing lesions present on the MRI?

- 1 yes
2 no
3 unknown

108. Specify number of lesions: number unknown

109. Are any new lesions present on the MRI?

- 1 yes
2 no
3 unknown

110. Specify the new lesions present:

- 1 gadolinium-enhancing
2 unenhancing
3 both
4 unknown

111. Was there evidence of disease activity present at the current evaluation?

- 1 yes
2 no
3 unknown

112. Specify the date of first evidence of disease activity at the current evaluation:
Month Day Year date unknown

113. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____