

ERROR CORRECTION FORM

Sequence Number:

CIBMTR Recipient ID:

Initials:

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Today's Date:

Infusion Date:

CIBMTR Center Number:

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Month	Day	Year			

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Therapy Given?	Reason for Therapy Code <small>see below</small>	Date Therapy Started	Currently Receiving?
		<small>Month Day Year</small>	
23. Methotrexate (MTX, Folex) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	24. <table border="1" style="width: 20px; height: 20px;"></table> 25. If Code 4 — Other reason, specify: _____	26. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
28. Mycophenolate mofetil (MMF, CellCept) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	29. <table border="1" style="width: 20px; height: 20px;"></table> 30. If Code 4 — Other reason, specify: _____	31. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
33. Phototherapy 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	34. <table border="1" style="width: 20px; height: 20px;"></table> 35. If Code 4 — Other reason, specify: _____	36. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
38. Prednisone (Intensol, Sterapred) or equivalent 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	39. <table border="1" style="width: 20px; height: 20px;"></table> 40. If Code 4 — Other reason, specify: _____	41. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
43. Prostanoids / prostaglandin analogs 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	44. <table border="1" style="width: 20px; height: 20px;"></table> 45. If Code 4 — Other reason, specify: _____	46. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
48. Tacrolimus (FK 506, Prograf) 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	49. <table border="1" style="width: 20px; height: 20px;"></table> 50. If Code 4 — Other reason, specify: _____	51. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	52. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
53. Other treatment 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unknown	54. <table border="1" style="width: 20px; height: 20px;"></table> 55. If Code 4 — Other reason, specify: _____	56. <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px;"></table> <table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	57. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
58. Specify other treatment: _____			

Reason for Therapy Codes				
1 planned per protocol	2 continued from prior to HSCT	3 relapse / progression of SSC	4 other reason	5 reason unknown

Disease Status at the Time of Evaluation for This Reporting Period

59. Date of evaluation for this reporting period:

Month Day Year

60. What was the extent of cutaneous systemic sclerosis at the time of evaluation for this report?
 1 limited (cutaneous thickening distal (but not proximal) to elbows or knees)
 2 diffuse
 3 unknown

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Specify skin thickness for the following sites as determined by clinical palpation performed at the time of evaluation for this report: *Clements P, Lachenbruch P, Seibold J, White B, Weiner S, Martin R, et al. Inter and intraobserver variability of total skin thickness score (modified Rodnan TSS) in systemic sclerosis. J Rheumatol 1995; 22:1281-1285.*

Anatomic Area	Modified Rodnan Skin Thickness Score (MRSS)				* Severe = inability to pinch skin into a fold		
	normal	mild	moderate	severe *			
61. Face	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
62. Anterior chest	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
63. Abdomen	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
64. Upper arm – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
65. Upper arm – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
66. Forearms – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
67. Forearms – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
68. Dorsum of hand – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
69. Dorsum of hand – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
70. Fingers – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
71. Fingers – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
72. Thigh – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
73. Thigh – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
74. Lower leg – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
75. Lower leg – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
76. Dorsum of foot – left	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
77. Dorsum of foot – right	1 <input type="checkbox"/> score 0	2 <input type="checkbox"/> score 1	3 <input type="checkbox"/> score 2	4 <input type="checkbox"/> score 3			
78. Total modified Rodnan Skin Score: (add scores from questions 61–77)					<table border="1" style="width: 40px; height: 20px;"><tr><td></td><td></td></tr></table>		

Specify the following clinical findings at the time of evaluation for this report:

79. Changes in skin pigmentation:

- 1 present
- 2 absent
- 3 unknown

80. Raynaud's phenomenon:

- 1 present
- 2 absent
- 3 unknown

81. Painful digital ulcers:

- 1 present
- 2 absent
- 3 unknown

82. Specify number of digital ulcers:

--	--

83. Gut dysmotility:

- 1 present
- 2 absent
- 3 unknown

84. Malabsorption:

- 1 present
- 2 absent
- 3 unknown

85. Weight loss > 10% of body weight:

- 1 present
- 2 absent
- 3 unknown

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86. Muscle weakness:

- 1 present
- 2 absent
- 3 unknown

87. Joint tenderness:

- 1 present
- 2 absent
- 3 unknown

88. Specify number of joints affected:

--	--

89. Tendon friction rubs:

- 1 present
- 2 absent
- 3 unknown

90. Specify number of sites affected:

--	--

91. Contractures:

- 1 present
- 2 absent
- 3 unknown

Laboratory Studies at the Time of Evaluation for This Reporting Period

92. Serum creatinine:

- 1 known →

--	--

 .

--	--
- 2 not known

Specify units:

- 1 mg/dL
- 2 μmol/L
- 3 mmol/L

93. Creatinine clearance:

- 1 known →

--	--	--	--

 .

--	--
- 2 not known

- 1 mL/min
- 2 mL/sec

94. Creatinine phosphokinase:

- 1 known →

--	--	--	--

 .

--	--
- 2 not known

- 1 U/L
- 2 μkat/L

95. Blood urea nitrogen:

- 1 known →

--	--

 .

--
- 2 not known

- 1 mg/dL
- 2 mmol/L

96. Was there evidence of hematuria at the time of evaluation for this report?

- 1 yes, present
- 2 no, absent
- 3 unknown

97. Was there evidence of proteinuria at the time of evaluation for this report?

- 1 yes, present
- 2 no, absent
- 3 unknown

98. Thyroid stimulating hormone (TSH):

- 1 known →

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 .

--
- 2 not known

- 1 mU/L
- 2 μU/mL

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99. Was any testing for autoantibodies performed since the date of the last report?

- 1 yes
- 2 no
- 3 unknown

Specify the test results for the following autoantibodies:

- | | | | | |
|---|-------------------------------------|-------------------------------------|---|---|
| 100. Anti-centromere: | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested / unknown |
| 101. Anti-DNA topoisomerase I (Scl-70): | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested / unknown |
| 102. Anti-nuclear: | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested / unknown |
| 103. Anti-SS-A: | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested / unknown |
| 104. Anti-SS-B: | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested / unknown |

Specify the results of the following pulmonary function tests performed since the date of the last report:

105. Was dyspnea present on exertion?

- 1 yes
- 2 no
- 3 unknown

106. Vital capacity (VC):

- 1 known →

 .

 % (predicted value)
- 2 not known

107. Was the actual VC value in the normal range (≥ 80% of predicted value)?

- 1 yes
- 2 no

108. D_LCO:

- 1 known →

 .

 % (predicted value)
- 2 not known

109. Was the actual D_LCO value in the normal range (≥ 80% of predicted value)?

- 1 yes
- 2 no

110. D_LCO corrected for hemoglobin:

- 1 known →

 .

 % (predicted value)
- 2 not known

111. Was the D_LCO value (corrected for hemoglobin) in the normal range (≥ 80% of predicted value)?

- 1 yes
- 2 no

112. Was oxygen desaturation present on exercise testing?

- 1 yes
- 2 no
- 3 unknown

113. Was ground glass appearance present on chest x-ray?

- 1 yes
- 2 no
- 3 unknown

114. Was a high resolution chest CT scan performed?

- 1 yes
- 2 no
- 3 unknown

115. Was ground glass appearance present on CT scan?

- 1 yes
- 2 no
- 3 unknown

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2 0
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116. Was pulmonary artery hypertension present?

- 1 yes
2 no
3 unknown

117. Specify the mean pulmonary artery pressure (PAP) level:

- 1 known mm/Hg
2 unknown

118. Specify the method used to examine the PAP level:

- 1 echocardiogram
2 catheterization

119. Was systemic hypertension present that required treatment?

- 1 yes
2 no
3 unknown

Specify treatment(s) given for hypertension:

120. ACE inhibitor

- 1 yes
2 no

121. Other antihypertensive therapy

- 1 yes
2 no

122. Specify antihypertensive therapy:

123. Specify the duration of antihypertensive therapy: months

124. Was arrhythmia present that required treatment?

- 1 yes
2 no
3 unknown

125. Was an echocardiogram performed at the time of evaluation for this report?

- 1 yes
2 no
3 unknown

126. Was pericardial effusion present?

- 1 yes
2 no
3 unknown

127. Specify the size of the area of accumulated excess fluid:

- 1 small
2 moderate
3 large

128. Specify the left ventricular ejection fraction:

- 1 known %
2 not known

129. Was a multiple gate acquisition scan (MUGA test / nuclear ventriculography) performed at the time of evaluation for this report?

- 1 yes
2 no
3 unknown

130. Specify the left ventricular ejection fraction: %

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Functional Assessment at the Time of Evaluation for This Report

131. Did the recipient complete a modified Health Assessment Questionnaire (HAQ) for Scleroderma at the time of evaluation for this report?

Steen VD, Medsger Jr. TA. The value of the Health Assessment Questionnaire and special patient-generated scales to demonstrate change in systemic sclerosis patients over time. Arthritis Rheum 1997; 40 (11): 1984-1991.

- 1 yes
2 no
3 unknown

132. Recipient's score:

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133. Worst possible score:

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134. Best possible score:

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135. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____