ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day Year | Infusion Date: Month Day Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

Key Fields

Sequence Number: _____

Date Received: __ __ __ __ - __ __- __ __

CIBMTR Center Number: _____

CIBMTR Recipient ID: _____

Donor Information (1)

Specify donor:

- ○ Autologous
- ○ NMDP unrelatedcord blood unit
- ○ NMDP unrelateddonor
- ○ Related donor
- ○ non-NMDPunrelated donor
- ○ non-NMDP cord bloodunit (include relatedand autologous CBUs)

NMDP Cord Blood Unit ID _____

NMDP Donor ID: _____

Donor's / infant's date of birth: __ __ __ __ - __ __- __ __

Donor's / infant's gender:

○ male ○ female

Non-NMDP unrelated donor / cord blood unit ID: *(not applicable for related donor)* _____

Today's Date: __ __ __ __ - __ __- __ __

Date of HSCT for which this form is being completed: __ __ __ __ - __ __- __ __

HSCT type:

- ☐ Autologous
- ☐ Allogeneic, unrelated
- ☐ Allogeneic, related
- ☐ Syngeneic (identical twin)

Product type:

- ☐ Marrow
- ☐ PBSC
- ☐ Cord blood
- ☐ multiple cord blood units infused

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

☐ Other product

Specify: _____

Recipient Demographics — Questions: 1 - 8

1 Country of primary residence (check only one): _____

2 Other Country, Specify _____

3 State of residence of recipient (for residents of the USA): _____

4 Zip or postal code for place of recipient's residence (USA recipients only): _____

5 Gender:

○ male ○ female

6 Ethnicity

○ Hispanic or Latino

○ not Hispanic or Latino

○ not applicable, non-resident of USA

Race (1)

7 Race: (Mark the group(s) in which the recipient is a member . Check all that apply.) _____

8 Date of birth: __ __ __ __ - __ __- __ __

Primary Disease for HSCT — Questions: 9 - 20

9 What was the primary disease for which the HSCT was performed? _____

10 What was the disease subtype? _____

11 Did AML transform from MDS / MPS?

○ yes ○ no

12 Was AML therapy-related?

○ yes ○ no ○ Unknown

13 Was AML alkylating agent / radiation-related?

○ yes ○ no ○ Unknown

14 Was AML topoisomerase II inhibitor-related?

○ yes ○ no ○ Unknown

15 Was MDS / MPS therapy-related?

○ yes ○ no ○ Unknown

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

16 Was MDS / MPS alkylating agent / radiation-related?

○ yes ○ no ○ Unknown

17 Was MDS / MPS topoisomerase II inhibitor-related?

○ yes ○ no ○ Unknown

18 Also check subtype below:

○ intravascular large B-cell lymphoma

○ mediastinal large B-cell lymphoma

○ primary effusion lymphoma

19 other disease, specify _____

20 Is a pathology report attached to this form?

○ yes ○ no

Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

Questions: 21 - 142

21 For allogeneic HSCTs only: What is the recipient's blood type and Rh factor?

○ A positive ○ A negative ○ B positive ○ B negative ○ AB positive ○ AB negative ○ O positive ○ O negative

If the recipient is 16 years of age or older, complete the Karnofsky Scale. If the recipient is younger than 16 years of age, complete the Lansky Scale.

22 Karnofsky Lansky type

○ Karnofsky ○ Lansky

23 What was the functional status of the recipient prior to the preparative regimen? _____

24 Was there a history of malignancy other than the primary disease for which this HSCT is being performed?

○ yes ○ no

Specify which malignancy(ies) occured:

25 Acute myeloid leukemia (AML / ANLL)

○ yes ○ no

26 Year of diagnosis: _____

27 Other leukemia, including ALL

○ yes ○ no

28 Year of diagnosis: _____

29 Specify leukemia: _____

30 Breast cancer

○ yes ○ no

31 Year of diagnosis: _____

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

32 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

○ yes ○ no

33 Year of diagnosis: _____

34 Clonal cytogenetic abnormality without leukemia or MDS

○ yes ○ no

35 Year of diagnosis: _____

36 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

○ yes ○ no

37 Year of diagnosis: _____

38 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)

○ yes ○ no

39 Year of diagnosis: _____

40 Hodgkin disease

○ yes ○ no

41 Year of diagnosis: _____

42 Lung cancer

○ yes ○ no

43 Year of diagnosis: _____

44 Lymphoma or lymphoproliferative disease

○ yes ○ no

45 Year of diagnosis: _____

46 Is the tumor EBV positive?

○ yes ○ no

47 Melanoma

○ yes ○ no

48 Year of diagnosis: _____

49 Other skin malignancy (basal cell, squamous)

○ yes ○ no

50 Year of diagnosis: _____

51 Specify skin malignancy: _____

52 Myelodysplasia (MDS) / myeloproliferative (MPS) disorder

○ yes ○ no

53 Year of diagnosis: _____

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

54 Oropharyngeal cancer (tongue, buccal mucosa)

○ yes ○ no

55 Year of diagnosis: _____

56 Sarcoma

○ yes ○ no

57 Year of diagnosis: _____

58 Thyroid cancer

○ yes ○ no

59 Year of diagnosis: _____

60 Other prior malignancy

○ yes ○ no

61 Year of diagnosis: _____

62 Specify other malignancy: _____

63 Were there *clinically significant* coexisting diseases or organ impairment at any time prior to the preparative regimen?

○ yes ○ no

Specify the diagnosis:

64 Significant hemorrhage (GI, GU or CNS)

○ yes ○ no

Specify hemorrhage site:

65 Gastrointestinal (GI) / ulcers

○ yes ○ no

66 Genitourinary (GU)/hemorrhagic cystitis

○ yes ○ no

67 Central nervous system (CNS)

○ yes ○ no

68 Autoimmune disease

○ yes ○ no

Specify diagnosis:

69 multiple sclerosis (MS)

○ yes ○ no

70 polyarteritis nodosa

○ yes ○ no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

71 psoriasis

yes no

72 rheumatoid arthritis (RA)

yes no

73 systemic lupus erythematosis (SLE)

yes no

74 Other

yes no

75 Specify: _____

76 Cardiovascular

yes no

Specify diagnosis:

77 atrial fibrillation

yes no

78 other arrhythmias

yes no

79 congestive heart failure (CHF) (EF < 50%)

yes no

80 coronary artery disease (no prior MI)

yes no

81 hypertension

yes no

82 myocardial infarction (MI)

yes no

83 Other

yes no

84 Specify: _____

85 Chromosomal abnormality

yes no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

Specify abnormality:

86 Down syndrome

yes no

87 Fanconi anemia

yes no

88 Other

yes no

89 Specify: _____

90 CNS / psychiatric

yes no

Specify diagnosis:

91 depression requiring treatment

yes no

92 paralysis

yes no

93 meningitis / encephalitis

yes no

94 seizure disorder

yes no

95 stroke / cerebrovascular accident (CVA)

yes no

96 Other

yes no

97 Specify: _____

98 Endocrine

yes no

Specify diagnosis:

99 adrenal insufficiency

yes no

100 diabetes mellitus

yes no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

101 osteoporosis

yes no

102 thyroid disease

yes no

103 Other

yes no

104 Specify: _____

105 Gastrointestinal

yes no

Specify diagnosis:

106 Crohn's disease

yes no

107 peptic ulcer disease (PUD)

yes no

108 gastroesophageal reflux disease (GERD)

yes no

109 ulcerative colitis

yes no

110 Other

yes no

111 Specify: _____

112 Genitourinary

yes no

Specify diagnosis:

113 renal failure requiring dialysis

yes no

114 renal insufficiency requiring medical treatment

yes no

115 Other

yes no

116 Specify: _____

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

117 Hematologic

○ yes ○ no

Specify diagnosis:

118 deep vein thrombosis / pulmonary embolism

○ yes ○ no

119 Other

○ yes ○ no

120 Specify: _____

121 Liver disease

○ yes ○ no

Specify:

122 drug toxicity

○ yes ○ no

123 hepatitis A virus

○ yes ○ no

124 hepatitis B virus

○ yes ○ no

125 hepatitis C virus

○ yes ○ no

126 Other

○ yes ○ no

127 Specify: _____

128 Neonatal GVHD

○ yes ○ no

129 Pulmonary

○ yes ○ no

Specify diagnosis:

130 asthma / reactive airway disease

○ yes ○ no

131 restrictive lung disease

○ yes ○ no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

132 chronic obstructive pulmonary disease (COPD)

○ yes ○ no

133 carbon monoxide diffusing capacity (DLco) < 50%

○ yes ○ no

134 Other

○ yes ○ no

135 Specify: _____

136 Other significant coexisting disease

○ yes ○ no

137 Specify: _____

138 Does the recipient have a history of smoking cigarettes?

○ yes ○ no ○ Unknown

139 Has the recipient smoked cigarettes within the past year?

○ yes ○ no ○ Unknown

140 Has the recipient smoked cigarettes prior to but not during the past year?

○ yes ○ no ○ Unknown

141 Number of years: _____ ☐ duration unknown

142 Average number of packs per day: _____ ☐ amount unknown

Organ Function Prior to the Preparative Regimen (Conditioning) Questions: 143 - 154

143 AST (SGOT): _____ ○ U/L ○ µkat/L

☐ AST (SGOT) not tested

144 Date tested: __ __ __ __ - __ __- __ __

145 Upper limit of normal for your institution: _____

146 Total serum bilirubin: _____ ○ mg/dL ○ µmol/L

☐ Total serum bilirubin not tested

147 Date tested: __ __ __ __ - __ __- __ __

148 Upper limit of normal for your institution: _____

149 LDH: _____ ○ U/L ○ µkat/L

☐ LDH not tested

150 Date tested: __ __ __ __ - __ __- __ __

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

151 Upper limit of normal for your institution: _____

152 Serum creatinine: _____ ○ mg/dL ○ µmol/L ○ mmol/L

☐ Serum creatinine not tested

153 Date tested: __ __ __ __ - __ __ - __ __

154 Upper limit of normal for your institution: _____

Hematologic Findings Prior to the Preparative Regimen (Conditioning)

Questions: 155 - 164

155 Date CBC tested: __ __ __ __ - __ __ - __ __ (testing done within 30 days of start of preparative regimen)

156 WBC: _____ ○ x 10^9/L (x 10^3/mm^3) ○ x 10^6/L

☐ WBC not tested

157 Neutrophils: _____ % ☐ Neutrophils not tested

158 Lymphocytes: _____ % ☐ Lymphocytes not tested

159 Hemoglobin: _____ ○ g/dL ○ g/L ○ mmol/L

☐ Hemoglobin not tested

160 Was RBC transfused < 30 days before date CBC tested?

○ yes ○ no

161 Hematocrit: _____ % ☐ Hematocrit not tested

162 Was RBC transfused < 30 days before date CBC tested?

○ yes ○ no

163 Platelets: _____ ○ x 10^9/L (x 10^3/mm^3) ○ x 10^6/L

☐ Platelets not tested

164 Were platelets transfused < 7 days before date CBC tested?

○ yes ○ no

Infection

Questions: 165 - 185

165 Did the recipient have a history of *clinically significant* fungal infection (documented or suspected) at any time prior to the preparative regimen?

○ yes ○ no

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

166 Did the recipient have more than one fungal infection (documented or suspected) at any time prior to the preparative regimen?

○ yes ○ no

Fungal Infections (1) **Questions: 167 - 173**

167 Date of onset: __ __ __ __ - __ __- __ __

168 Select organism from list below: _____

169 If 209, 219, or 259, specify organism: _____

170 Select site(s) from list below: _____

171 Specify site: _____

172 Specify site: _____

173 Was this fungal infection active within 2 weeks prior to the preparative regimen?

○ yes ○ no

Testing for serological evidence of prior viral exposure/infection

174 HTLV1 antibody

○ Positive ○ Negative ○ Inconclusive ○ Not tested

175 Cytomegalovirus antibody

○ Positive ○ Negative ○ Inconclusive ○ Not tested

176 Epstein-Barr antibody

○ Positive ○ Negative ○ Inconclusive ○ Not tested

177 Hepatitis B surface antibody

○ Positive ○ Negative ○ Inconclusive ○ Not tested

178 Hepatitis B core antibody

○ Positive **- For hepatitis types that have a positive result, also complete HEP form.**

○ Negative

○ Inconclusive

○ Not tested

179 Hepatitis B surface antigen

○ Positive **- For hepatitis types that have a positive result, also complete HEP form.**

○ Negative

○ Inconclusive

○ Not tested

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

180 Hepatitis B — DNA

- ○ Positive **- For hepatitis types that have a positive result, also complete HEP form.**
- ○ Negative
- ○ Inconclusive
- ○ Not tested

181 Hepatitis C antibody

- ○ Positive **- For hepatitis types that have a positive result, also complete HEP form.**
- ○ Negative
- ○ Inconclusive
- ○ Not tested

182 Hepatitis C – NAT

- ○ Positive **- For hepatitis types that have a positive result, also complete HEP form.**
- ○ Negative
- ○ Inconclusive
- ○ Not tested

183 Hepatitis A antibody

- ○ Positive ○ Negative ○ Inconclusive ○ Not tested

184 HIV antibody

- ○ Not reported
- ○ Positive **- For HIV tests that have a positive result, also complete HIV form.**
- ○ Negative
- ○ Inconclusive
- ○ Not tested

185 HIV – NAT

- ○ Not reported
- ○ Positive **- For HIV tests that have a positive result, also complete HIV form.**
- ○ Negative
- ○ Inconclusive
- ○ Not tested

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day Year | Infusion Date: Month Day Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

Pre-HSCT Preparative Regimen (Conditioning) — Questions: 186 - 373

186 Height at initiation of pre-HSCT preparative regimen: _____ ○ in ○ cm

187 Actual weight at initiation of pre-HSCT preparative regimen: _____ ○ lbs ○ kg

188 Dosing body weight used for pre-HSCT preparative regimen (adjusted body weight): _____ ○ lbs ○ kg

189 Was pre-HSCT preparative regimen given?

○ yes ○ no

190 Specify protocol requirement: *(check only one)*

○ all agents given as outpatient

○ some, but not all, agents given as inpatient

○ all agents given as inpatient

191 Classify the recipient's preparative regimen:

○ Myeloablative ○ Non-myeloablative ○ Reduced intensity

192 Date pre-HSCT preparative regimen (irradiation or drugs) began: __ __ __ __ - __ __ - __ __ (Use earliest date from questions 196, 202, 208 radiation or 234-367)

193 Was irradiation performed as part of the pre-HSCT preparative regimen?

○ yes ○ no

194 What was the radiation field?

○ total body

○ total body by tomotherapy

○ total lymphoid or nodal regions

○ thoracoabdominal region

195 Total dose: _____ ○ Gy ○ cGy (dose per fraction x total number of fractions)

196 Date started: __ __ __ __ - __ __ - __ __

197 Was the radiation fractionated?

○ yes ○ no

198 Dose per fraction: _____ ○ Gy ○ cGy

199 Number of days: _____ (include "rest" days)

200 Total number of fractions: _____

201 Total dose: _____ ○ Gy ○ cGy (dose per fraction x total number of fractions)

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

202 Date started: __ __ __ __ - __ __- __ __

203 Was the radiation fractionated?

○ yes ○ no

204 Dose per fraction: _____ ○ Gy ○ cGy

205 Number of days: _____ (include "rest" days)

206 Total number of fractions: _____

207 Total dose: _____ ○ Gy ○ cGy (dose per fraction x total number of fractions)

208 Date started: __ __ __ __ - __ __- __ __

209 Was the radiation fractionated?

○ yes ○ no

210 Dose per fraction: _____ ○ Gy ○ cGy

211 Number of days: _____ (include "rest" days)

212 Total number of fractions: _____

213 Was additional radiation given to other sites within 14 days of pre-HSCT preparative regimen?

○ yes ○ no

Specify radiation field:

214 CNS

○ yes ○ no

215 Total dose: _____ ○ Gy ○ cGy

216 Date started: __ __ __ __ - __ __- __ __

217 Gonadal

○ yes ○ no

218 Total dose: _____ ○ Gy ○ cGy

219 Date started: __ __ __ __ - __ __- __ __

220 Splenic

○ yes ○ no

221 Total dose: _____ ○ Gy ○ cGy

222 Date started: __ __ __ __ - __ __- __ __

223 Site of residual tumor

○ yes ○ no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

224 Total dose: _____ ○ Gy ○ cGy

225 Date started: __ __ __ __ - __ __- __ __

226 Specify site: _____

227 Other site:

○ yes ○ no

228 Total dose: _____ ○ Gy ○ cGy

229 Date started: __ __ __ __ - __ __- __ __

230 Specify site: _____

231 Were drugs given for pre-HSCT preparative regimen?

○ yes ○ no

232 ALG, ALS, ATG, ATS

○ yes ○ no

233 Total dose: _____ mg

234 Date started: __ __ __ __ - __ __- __ __

235 Specify source:

○ Horse ○ Rabbit ○ Other

236 Specify: _____

237 Anthracycline:

○ yes ○ no

238 Daunorubicin

○ yes ○ no

239 Total dose: _____ mg

240 Date started: __ __ __ __ - __ __- __ __

241 doxorubicin (adriamycin)

○ yes ○ no

242 Total dose: _____ mg

243 Date started: __ __ __ __ - __ __- __ __

244 Idarubicin (Idamycin)

○ yes ○ no

245 Total dose: _____ mg

246 Date started: __ __ __ __ - __ __- __ __

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

247 rubidazone

○ yes ○ no

248 Total dose: _____ mg

249 Date started: __ __ __ __ - __ __- __ __

250 other anthracycline

○ yes ○ no

251 Total dose: _____ mg

252 Date started: __ __ __ __ - __ __- __ __

253 Specify anthracycline: _____

254 Bleomycin

○ yes ○ no

255 Total dose: _____

256 Date started: __ __ __ __ - __ __- __ __

257 Busulfan (Myleran)

○ yes ○ no

258 Total dose: _____

259 Date started: __ __ __ __ - __ __- __ __

260 Specify administration:

○ Oral ○ IV ○ Both

261 Carboplatin

○ yes ○ no

262 Total dose: _____ mg

263 Date started: __ __ __ __ - __ __- __ __

264 Cisplatin

○ yes ○ no

265 Total dose: _____ mg

266 Date started: __ __ __ __ - __ __- __ __

267 Cladribine

○ yes ○ no

268 Total dose: _____ mg

269 Date Started: __ __ __ __ - __ __- __ __

270 Corticosteroids (excluding anti-nausea medication)

○ yes ○ no

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

271 methylprednisolone (Solu-Medrol)

○ yes ○ no

272 Total dose: _____ mg

273 Date started: __ __ __ __ - __ __- __ __

274 Specify administration:

○ Oral ○ IV ○ Both

275 prednisone

○ yes ○ no

276 Total dose: _____ mg

277 Date started: __ __ __ __ - __ __- __ __

278 dexamethasone

○ yes ○ no

279 Total dose: _____ mg

280 Date started: __ __ __ __ - __ __- __ __

281 other corticosteroid

○ yes ○ no

282 Total dose: _____ mg

283 Date started: __ __ __ __ - __ __- __ __

284 Specify corticosteroid: _____

285 Cyclophosphamide

○ yes ○ no

286 Total dose: _____ mg

287 Date started: __ __ __ __ - __ __- __ __

288 Cytarabine (Ara-C)

○ yes ○ no

289 Total dose: _____ mg

290 Date started: __ __ __ __ - __ __- __ __

291 Etoposide (VP-16)

○ yes ○ no

292 Total dose: _____ mg

293 Date started: __ __ __ __ - __ __- __ __

294 Fludarabine

○ yes ○ no

295 Total dose: _____ mg

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

296 Date started: __ __ __ __ - __ __- __ __

297 Ifosfamide

○ yes ○ no

298 Total dose: _____ mg

299 Date started: __ __ __ __ - __ __- __ __

300 Imantinib mesylate (STI571, Gleevec)

○ yes ○ no

301 Total dose: _____ mg

302 Date started: __ __ __ __ - __ __- __ __

303 Intrathecal chemotherapy

○ yes ○ no

304 intrathecal cytarabine (IT Ara-C)

○ yes ○ no

305 Total dose: _____ mg

306 Date started: __ __ __ __ - __ __- __ __

307 intrathecal methotrexate (IT MTX)

○ yes ○ no

308 Total dose: _____ mg

309 Date started: __ __ __ __ - __ __- __ __

310 intrathecal thiotepa

○ yes ○ no

311 Total dose: _____ mg

312 Date started: __ __ __ __ - __ __- __ __

313 other intrathecal drug

○ yes ○ no

314 Total dose: _____ mg

315 Date started: __ __ __ __ - __ __- __ __

316 Specify intrathecal drug: _____

317 Melphalan (L-Pam)

○ yes ○ no

318 Total dose: _____ mg

319 Date started: __ __ __ __ - __ __- __ __

320 Specify administration:

○ Oral ○ IV ○ Both

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

321 Mitoxantrone

○ yes ○ no

322 Total dose: _____ mg

323 Date started: __ __ __ __ - __ __- __ __

324 Monoclonal antibody

○ yes ○ no

325 radio labeled MAb

○ yes ○ no

326 Total dose of radioactive component: _____ ○ mCi ○ MBq

327 Date started: __ __ __ __ - __ __- __ __

Specify monoclonal antibody:

328 tositumomab (Bexxar)

○ yes ○ no

329 ibritumomab tiuxetan (Zevalin)

○ yes ○ no

330 Other

○ yes ○ no

331 Specify: _____

332 campath

○ yes ○ no

333 Total dose: _____ mg

334 Date started: __ __ __ __ - __ __- __ __

335 rituximab (Rituxan, anti CD20)

○ yes ○ no

336 Total dose: _____ mg

337 Date started: __ __ __ __ - __ __- __ __

338 gemtuzumab (Mylotarg, anti CD33)

○ yes ○ no

339 Total dose: _____ mg

340 Date started: __ __ __ __ - __ __- __ __

341 other MAb

○ yes ○ no

342 Total dose: _____ mg

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

343 Date started: __ __ __ __ - __ __- __ __

344 Specify other MAb: _____

345 Nitrosourea

○ yes ○ no

346 BCNU (Carmustine)

○ yes ○ no

347 Total dose: _____ mg

348 Date started: __ __ __ __ - __ __- __ __

349 CCNU (Lomustine)

○ yes ○ no

350 Total dose: _____ mg

351 Date started: __ __ __ __ - __ __- __ __

352 other nitrosourea

○ yes ○ no

353 Total dose: _____ mg

354 Date started: __ __ __ __ - __ __- __ __

355 Specify nitrosourea: _____

356 Paclitaxel (Taxol, Xyotax)

○ yes ○ no

357 Total dose: _____ mg

358 Date started: __ __ __ __ - __ __- __ __

359 Teniposide (VM26)

○ yes ○ no

360 Total dose: _____ mg

361 Date started: __ __ __ __ - __ __- __ __

362 Thiotepa

○ yes ○ no

363 Total dose: _____ mg

364 Date started: __ __ __ __ - __ __- __ __

365 other drug

○ yes ○ no

366 Total dose: _____ mg

367 Date started: __ __ __ __ - __ __- __ __

368 Specify other drug: _____

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

369 Were pharmacokinetics performed to determine preparative regimen drug dosing?

○ yes ○ no

Specify drugs:

370 Busulfan

○ yes ○ no

371 Cyclophosphamide

○ yes ○ no

372 other drug

○ yes ○ no

373 Specify other drug: _____

HSCT History

Questions: 374 - 391

374 Was this the first HSCT for this recipient?

○ yes ○ no

375 For autologous HSCTs only: Is a subsequent HSCT planned as part of the overall treatment protocol (not as a reaction to post-HSCT disease assessment)?

○ Yes

○ No

○ not applicable; allogeneic HSCT

376 Specify subsequent HSCT planned

○ subsequent autologous HSCT planned

○ subsequent allogeneic HSCT planned

377 Specify the number of prior HSCTs: _____

What was (were) the prior HSC source(s)?

378 Autologous

○ yes ○ no

379 Allogeneic, unrelated

○ yes ○ no

380 Allogeneic, related

○ yes ○ no

381 syngeneic

○ yes ○ no

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

382 Was the same donor used for all prior and current HSCTs?

○ yes ○ no

383 Date of the last HSCT (just before current HSCT): __ __ __ __ - __ __- __ __

384 Was the last HSCT performed at a different institution?

○ yes ○ no

385 Name: _____

City: _____

State/Country: _____

386 What was the HSC source for the last HSCT?

○ Autologous

○ Allogeneic, unrelated donor

○ syngeneic / allogeneic related donor

387 Reason for current HSCT:

○ No hematopoietic recovery

○ Partial hematopoietic recovery

○ Graft failure / rejection after achieving initial hematopoietic recovery

○ Persistent primary disease

○ Recurrent primary disease

○ Planned second HSCT, per protocol

○ New malignancy

○ stable, mixed chimerism

○ declining chimerism

○ Other, specify:

388 Date of graft failure / rejection: __ __ __ __ - __ __- __ __

389 Date of relapse: __ __ __ __ - __ __- __ __

390 Date of secondary malignancy: __ __ __ __ - __ __- __ __

391 Specify other reason: _____

Socioeconomic Information

Questions: 392 - 409

392 Is the recipient an adult (18 years of age or older) or emancipated minor?

○ yes ○ no

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

393 Specify recipient's marital status:

- ○ single, never married
- ○ married or living with a partner
- ○ separated
- ○ divorced
- ○ widowed
- ○ Unknown

394 Specify the category which best describes the recipient's current occupation. If the recipient is not currently employed, check the box which best describes his/her last job: _____

395 Specify other occupation: _____

396 What was the recipient's current or most recent work status prior to illness?

○ full time ○ part time ○ unemployed ○ medical disability ○ retired ○ Unknown

397 Specify retirement level:

- ○ with a source of income
- ○ no source of income

398 What is the highest educational grade the recipient completed:

- ○ No primary education / under school age: No schooling (US Equivalent: Less than 1st Grade Education)
- ○ Less than primary or elementary education: Some formal schooling, but less than a complete primary or elementary education (US Equivalent: More than 1st grade education, but less than 6th grade education)
- ○ Primary or elementary education: Beginning at age 5-7 and continuing for about 4-6 years (US Equivalent: Starts with 1st grade and ends with 6th grade)
- ○ Lower secondary education: Beginning at about age 11-12 and continuing for about 2-3 years (US Equivalent: Starts with 7th grade and typically ends with 9th grade)
- ○ Upper secondary education: Beginning at about age 15-16 and continuing for about 3 years (US Equivalent: Starts with 10th grade and ends with 12th grade)
- ○ Post-secondary, non-tertiary education: Programs lasting 6 months - 2 years (US Equivalent: Vocational programs of study)
- ○ Tertiary education, Type A: Programs that provide education that is largely theoretical, lasting 3-4 years (US Equivalent: Includes university programs that last 4 years and lead to the award of a bachelor's degree, and university programs that lead to a master's degree)
- ○ Tertiary education, Type B: Programs that focus on practical, technical or occupational skills with a minimum duration of 2 years of full-time enrollment (US Equivalent: Programs typically offered at community colleges that lead to an associate's degree)
- ○ Advanced research qualification: Programs that lead to the award of an advanced post-graduate degree, such as a Ph.D. (US Equivalent: Programs devoted to advanced study and original research)

399 Is the recipient currently in school, or was enrolled prior to illness?

○ yes ○ no ○ Unknown

400 Is the recipient covered by health insurance?

○ yes ○ no

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month / Day / 20 Year | Infusion Date: Month / Day / 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

Specify type of health insurance:

401 government-sponsored Medicaid (U.S.)

○ yes ○ no

402 government-sponsored Medicare (U.S.)

○ yes ○ no

403 government-sponsored National Health Insurance (non-U.S.)

○ yes ○ no

404 government-sponsored Veteran's Affairs / military

○ yes ○ no

405 private health insurance (premium paid by individual) or group health insurance

○ yes ○ no

406 employer-sponsored disability insurance

○ yes ○ no

407 Other

○ yes ○ no

408 Specify other health insurance: _____

409 For U.S. residents only: Specify the recipient's combined household gross annual income: *Include earnings by all family members living in the household, before taxes.*

- ○ Less than $20,000
- ○ $20,000–$39,999
- ○ $40,000–$59,999
- ○ $60,000–$79,999
- ○ $80,000–$99,999
- ○ $100,000 and over
- ○ Recipient declines to provide this information
- ○ Unknown

Consent Status

Questions: 410 - 413

410 Has the recipient signed an IRB-approved consent form to donate research blood samples to the CIBMTR?

○ yes ○ no

411 Date form was signed: __ __ __ __ - __ __ - __ __

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.

ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2000 R3.0: Recipient Baseline Data

Center: CRID:

---

412 Has the recipient signed an IRB-approved consent form for submitting research data to the CIBMTR?

○ yes ○ no

413 Date form was signed: __ __ __ __ - __ __- __ __

First Name: _____ Last Name: _____

Phone number: _____ Fax number: _____

E-mail address: _____

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.