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 2004 R3.0: Infectious Disease Markers

Center: CRID:

Key Fields

OMB No: 0915-0310

Expiration Date: 12/31/2013**Public Burden Statement**: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0310.Public reporting burden for this collection of information, in combination with the HLA Typing Form 2005 and HSCT Infusion Form 2006, is estimated to average 1.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.Expiration date: 12/31/2013

Sequence Number: _____

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

CIBMTR Center Number: _____

CIBMTR Recipient ID: _____

Specify non-NMDP donor:

- ○ Related donor – Complete donor's / infant's date of birth and donor's / infant's gender
- ○ Non-NMDP unrelated donor – Complete donor's / infant's date of birth, donor's / infant's gender and non-NMDP unrelated donor / cord blood unit ID
- ○ non-NMDP cord bloodunit (include relatedand autologous CBUs) – Complete donor's / infant's date of birth, donor's / infant's gender and non-NMDP unrelated donor / cord blood unit 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:

- ○ Allogeneic, unrelated
- ○ Allogeneic, related
- ○ syngeneic(identical twin)

Product type:

○ marrow ○ PBSC ○ Cord blood ○ other product

Specify: _____

This form must be completed for all non-NMDP allogeneic or syngeneic donors, or non-NMDP cord blood units. If the donor or cord blood unit was secured through the NMDP, then report IDMs on forms 24 and 50 for allogeneic donors or through CORD Link for cord blood units.

1 Who is being tested for IDMs?

- ○ donor IDM (marrow or PBSC)
- ○ maternal IDM (cord blood)
- ○ cord blood unit IDM

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

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Form 2004 R3.0: Infectious Disease Markers

Center: CRID:

Infectious Disease Marker (report final test results) — Questions: 2 - 36

Hepatitis B Virus (HBV)

2 HBsAg: (hepatitis B surface antigen)

- ○ Reactive
- ○ Non-reactive
- ○ testing not performed

3 Test date: __ __ __ __ - __ __- __ __

4 Anti HBc: (hepatitis B core antibody) *(no confirmatory test available)*

- ○ Reactive
- ○ Non-reactive
- ○ testing not performed

5 Test date: __ __ __ __ - __ __- __ __

Hepatitis C Virus (HCV)

6 Anti-HCV: (hepatitis C antibody)

- ○ Reactive
- ○ Non-reactive
- ○ testing not performed

7 Test date: __ __ __ __ - __ __- __ __

Human T-Lymphotropic Virus

8 Anti-HTLV I / II:

- ○ Reactive
- ○ Non-reactive
- ○ testing not performed

9 Test date: __ __ __ __ - __ __- __ __

Human Immunodeficiency Virus (HIV)

10 HIV-1 p24 antigen:

- ○ Reactive
- ○ Non-reactive
- ○ Not reported
- ○ not performed; HIV NAT testing performed *(skip date)*

11 Test date: __ __ __ __ - __ __- __ __

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Form 2004 R3.0: Infectious Disease Markers

Center: CRID:

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12 Was FDA licensed NAT testing for HIV-1/HCV performed?

○ yes ○ no

Specify results:

13 HIV-1

○ Positive ○ Negative ○ Not reported

14 Test date: __ __ __ __ - __ __- __ __

15 HCV

○ Positive ○ Negative

16 Test date: __ __ __ __ - __ __- __ __

17 Anti-HIV 1 and anti-HIV 2*: (antibodes to Human Immunodeficiency Viruses)

* Testing for both HIV antibodies is required. This testing may be performed as separate tests or done using a combined assay.

○ Reactive

○ Non-reactive

○ testing not performed

○ Not reported

18 Test date: __ __ __ __ - __ __- __ __

Syphilis

19 STS:

○ Reactive

○ Non-reactive

○ testing not performed

20 Test date: __ __ __ __ - __ __- __ __

Cytomegalovirus (CMV)

21 Anti-CMV: (IgG or Total)

○ Reactive

○ Non-reactive

○ testing not performed

22 Test date: __ __ __ __ - __ __- __ __

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Form 2004 R3.0: Infectious Disease Markers

Center: CRID:

West Nile Virus (WNV)

23 WNV-NAT testing:

- ○ Positive
- ○ Negative
- ○ testing not performed
- ○ Not applicable

24 Test date: __ __ __ __ - __ __- __ __

25 Other infectious disease marker, specify (e.g., EBV):

○ yes ○ no

26 Specify date performed: __ __ __ __ - __ __- __ __

27 Specify test and method: _____

28 Specify test results: _____

29 Other infectious disease marker, specify (e.g., EBV):

○ yes ○ no

30 Specify date performed: __ __ __ __ - __ __- __ __

31 Specify test and method: _____

32 Specify test results: _____

33 Other infectious disease marker, specify (e.g., EBV):

○ yes ○ no

34 Specify date performed: __ __ __ __ - __ __- __ __

35 Specify test and method: _____

36 Specify test results: _____

First Name: _____ Last Name: _____

Phone number: _____ Fax number: _____

E-mail address: _____

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