ERROR CORRECTION FORM

Sequence Number: | | | | | | | | | | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Initials: | | | |

Today's Date: | | Month | | | Day | 2 0 | | Year

Infusion Date: | | Month | | | Day | 2 0 | | Year

CIBMTR Center Number: | | | | | |

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Hematopoietic Cell Transplant Canceled or Delayed

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: ___ ___ ___ ___ ___

CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Today's Date: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

Date of HCT canceled for which this form is being completed: ___ ___ ___ ___ — ___ ___ — ___ ___
YYYY MM DD

HCT type (check all that apply):

- ☐ Autologous
- ☐ Allogeneic, unrelated
- ☐ Allogeneic, related

Product type (check all that apply):

- ☐ Marrow
- ☐ PBSC
- ☐ Cord blood
- ☐ Other product,

  Specify: _____

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Infusion Date: | | Month | | | Day | 2 0 | | Year

CIBMTR Center Number: | | | | | |

1. Reason for cancelation or delay:
   - ☐ Patient died ***Go to question 12***
   - ☐ HCT was canceled, but patient is alive ***Go to question 2***

2. Has the date of HCT been rescheduled?
   - ☐ Yes ***Go to question 3***
   - ☐ No ***Go to question 4***

3. Specify revised date of HCT: ___ ___ ___ ___ — ___ ___ — ___ ___
   YYYY MM DD

4. Was at least one dose of the preparative regimen given?
   - ☐ Yes
   - ☐ No

Specify the reason(s) for the HCT cancelation or delay:

5. Disease relapse / progression
   - ☐ Yes
   - ☐ No

6. Patient has an infection
   - ☐ Yes
   - ☐ No

7. Patient's organ function declined
   - ☐ Yes
   - ☐ No

8. Patient sent to hospice or receiving palliative care only
   - ☐ Yes
   - ☐ No

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9. HCT delayed due to donor availability

☐ Yes

☐ No

10. Other reason

☐ Yes – ***Go to question 11***

☐ No – ***Go to question 12***

11. Specify other reason: _____

12. Signed: _____

Person completing form

Please print name: _____

E-mail address: _____

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