

ERROR CORRECTION FORM

Sequence Number:

CIBMTR Recipient ID:

Initials:

Today's Date:

Infusion Date:

CIBMTR Center Number:

Form 2010 R3.0: Acute Myelogenous Leukemia (AML) Pre-HCT Data

Center: _____ CRID: _____

Key Fields

Sequence Number: _____

Date Received: ____ - ____ - ____

CIBMTR Center Number: _____

CIBMTR Recipient ID: _____

Date of HCT for which this form is being completed: ____ - ____ - ____

HCT Type: (check all that apply)

Autologous

Allogeneic, unrelated

Allogeneic, related

Product type: (check all that apply)

Bone marrow

PBSC

Single cord blood unit

Multiple cord blood units

Other product

Specify: _____

Subsequent Transplant

Is this the report of a second or subsequent transplant for the same disease?

yes no

Disease Assessment at Diagnosis Questions: 1 - 18

1 What was the date of diagnosis? ____ - ____ - ____

2 Is the disease (AML) therapy related?

(not MDS / MPN)

yes no Unknown

3 Specify prior disease

Breast cancer

Hodgkin lymphoma

Non-Hodgkin lymphoma

Other disease

4 Specify other prior disease: _____

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Center: _____ CRID: _____

5 Date of diagnosis of prior disease

Known Unknown

6 Date of diagnosis of prior disease: ____ - ____ - ____

7 Systemic therapy
(chemotherapy)

yes no Unknown

8 Radiation

yes no Unknown

9 Other therapy

yes no Unknown

10 Specify other therapy: _____

11 Did the recipient have an antecedent hematologic disorder?
(preleukemia or myelodysplastic syndrome)

yes no Unknown

12 Specify if the antecedent hematologic disorder was

- Documented
- Suspected (e.g. MDS suspected with AML diagnosis)
- Concurrent (e.g. MDS concurrent with AML diagnosis)

13 What was the date of diagnosis of antecedent hematologic disorder? ____ - ____ - ____

14 What was the classification of the hematologic disorder at diagnosis?

15 Specify other hematologic disorder: _____

16 Did the recipient have a predisposing condition?

yes no Unknown

17 Specify condition

- Bloom syndrome
- Down syndrome
- Fanconi anemia **Also complete CIBMTR Form 2029 - FAN**
- Neurofibromatosis type 1
- Other condition

18 Specify other condition: _____

ERROR CORRECTION FORM

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Today's Date:

 20

Month

Day

Year

Infusion Date:

 20

Month

Day

Year

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Center:

CRID:

Report findings prior to any first treatment of the primary disease for which the HCT is being performed.

19 WBC

Known Unknown

20 _____ x 10⁹/L (x 10⁹/mm³)

x 10⁶/L

21 Date sample collected: _____ - _____ - _____

22 Blasts in blood

Known Unknown

23 _____ %

24 Date sample collected: _____ - _____ - _____

25 Blasts in bone marrow

Known Unknown

26 _____ %

27 Date sample collected: _____ - _____ - _____

28 Was extramedullary disease present?

yes no Unknown

Specify site(s) of disease:

29 Central nervous system

yes no

30 Mouth / gums

yes no

31 Skin

yes no

32 Soft tissue

yes no

33 Testes

yes no

34 Other site

yes no

35 Specify other site: _____

36 Were cytogenetics tested (conventional or FISH)?

yes no Unknown

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Center: _____ CRID: _____

37 Date sample collected: ____-____-____

38 Results of tests

- Abnormalities identified
- No evaluable metaphases
- No abnormalities

Specify cytogenetic abnormalities identified at diagnosis: Monosomy

39 -5

yes no

40 -7

yes no

41 -17

yes no

42 -18

yes no

43 -X

yes no

44 -Y

yes no

Trisomy

45 +4

yes no

46 +8

yes no

47 +11

yes no

48 +13

yes no

49 +14

yes no

50 +21

yes no

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51 +22

yes no

Translocation

52 t(3;3)

yes no

53 t(6;9)

yes no

54 t(8;21)

yes no

55 t(9;11)

yes no

56 t(9;22)

yes no

57 t(15;17) and variants

yes no

58 t(16;16)

yes no

Deletion

59 del(3q) / 3q-

yes no

60 del(5q) / 5q-

yes no

61 del(7q) / 7q-

yes no

62 del(9q) / 9q-

yes no

63 del(11q) / 11q-

yes no

64 del(16q) / 16q-

yes no

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65 del(17q) / 17q-
 yes no

66 del(20q) / 20q-
 yes no

67 del(21q) / 21q-
 yes no

Inversion

68 inv(3)
 yes no

69 inv(16)
 yes no

Other

70 (11q23) any abnormality
 yes no

71 12p any abnormality
 yes no

72 Complex - ≥ 3 distinct abnormalities
 yes no

73 Other abnormality
 yes no

74 Specify other abnormality: _____

75 Was documentation submitted to the CIBMTR?
 (e.g. cytogenetic or FISH report)
 yes no

76 Were tests for molecular markers performed (e.g. PCR)?
 yes no Unknown

77 Date sample collected: ____-____-____

78 CEBPA
 Positive Negative Not Done

79 FLT3 – D835 point mutation
 Positive Negative Not Done

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Center: _____ CRID: _____

80 FLT3 – ITD mutation

Positive Negative Not Done

81 IDH1

Positive Negative Not Done

82 IDH2

Positive Negative Not Done

83 KIT

Positive Negative Not Done

84 NPM1

Positive Negative Not Done

Other Molecular Marker (1)

Questions: 85 - 86

85 Other molecular marker

Positive Negative Not Done

86 Specify other molecular marker: _____

87 Was documentation submitted to the CIBMTR?

yes no

Pre-HCT Therapy

Questions: 88 - 126

88 Was therapy given?

yes no

Line of Therapy (1)

Questions: 89 - 125

Line of Therapy:

89 Purpose of therapy

- Induction
- Consolidation
- Maintenance
- treatment for disease relapse

90 Systemic therapy

yes no

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Center: _____ CRID: _____

91 Date therapy started

Known Unknown

92 Date started: ____-____-____

93 Date therapy stopped

Known Unknown

94 Date stopped: ____-____-____

95 Number of cycles

Known Unknown

96 Number of cycles: _____

97 Azacytidine (Vidaza)

yes no

98 All-trans retinoic acid (Tretinoin)

yes no

99 Arsenic

yes no

100 Clofarabine

yes no

101 Cytarabine (Ara - C) ≤ 10 g/m2/cycle

yes no

102 Cytarabine (Ara - C) > 10 g/m2/cycle

yes no

103 Daunorubicin (Cerubidine)

yes no

104 Decitabine (Dacogen)

yes no

105 Etoposide (VP-16, VePesid)

yes no

106 Gemtuzumab (Mylotarg)

yes no

107 Idarubicin (Idamycin)

yes no

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108 Intrathecal therapy

yes no

109 Mitoxantrone (Novantrone)

yes no

110 Sorafenib

yes no

111 Thioguanine (6-TG)

yes no

112 Other systemic therapy

yes no

113 Specify other systemic therapy: _____

114 Radiation therapy

yes no

115 Date therapy started

Known Unknown

116 Date started: ____ - ____ - ____

117 Date therapy stopped

Known Unknown

118 Date stopped: ____ - ____ - ____

Specify site(s) of radiation therapy:

119 Central nervous system

yes no

120 Other site

yes no

121 Specify other site: _____

122 Best response to line of therapy

- Complete - A treatment response where all of the following criteria are met for at least four weeks: < 5% blasts in the bone marrow, normal maturation of remission (CR) all cellular components in the bone marrow (myeloid, erythroid, and megakaryocytic lineages), no blasts with Auer rods, no extramedullary disease (e.g., central nervous system or soft tissue involvement), ANC of > 1,000/ μ L, Platelets \geq 100,000/ μ L
- No complete remission

123 Date assessed: ____ - ____ - ____

124 Did the recipient relapse following this line of therapy?

yes no

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Center: _____ CRID: _____

125 Date of relapse: ____-____-____

126 Did the recipient have central nervous system leukemia at any time prior to the start of the preparative regimen?

yes no Unknown

Laboratory Studies at Last Evaluation Prior to the Start of the Preparative Regimen (Conditioning) Questions: 127 - 192

127 WBC

Known Unknown

128 _____ x 10⁹/L (x 10³/mm³)
 _____ x 10⁶/L

129 Date sample collected: ____-____-____

130 Blasts in blood

Known Unknown

131 _____ %

132 Date sample collected: ____-____-____

133 Blasts in bone marrow

Known Unknown

134 _____ %

135 Date sample collected: ____-____-____

136 Were cytogenetics tested (conventional or FISH)?

yes no Unknown

137 Date sample collected: ____-____-____

138 Results of tests

Abnormalities identified
 No evaluable metaphases
 No abnormalities

Specify cytogenetic abnormalities identified at last evaluation prior to the start of the preparative regimen: Monosomy

139 -5

yes no

140 -7

yes no

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Center: _____ CRID: _____

141 -17

yes no

142 -18

yes no

143 -X

yes no

144 -Y

yes no

Trisomy

145 +4

yes no

146 +8

yes no

147 +11

yes no

148 +13

yes no

149 +14

yes no

150 +21

yes no

151 +22

yes no

Translocation

152 t(3;3)

yes no

153 t(6;9)

yes no

154 t(8;21)

yes no

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Center: _____ CRID: _____

155 t(9;11)
 yes no

156 t(9;22)
 yes no

157 t(15;17) and variants
 yes no

158 t(16;16)
 yes no

Deletion

159 del(3q) / 3q-
 yes no

160 del(5q) / 5q-
 yes no

161 del(7q) / 7q-
 yes no

162 del(9q) / 9q-
 yes no

163 del(11q) / 11q-
 yes no

164 del(16q) / 16q-
 yes no

165 del(17q) / 17q-
 yes no

166 del(20q) / 20q-
 yes no

167 del(21q) / 21q-
 yes no

Inversion

168 inv(3)
 yes no

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Center: _____ CRID: _____

169 inv(16)
 yes no

Other

170 (11q23) any abnormality
 yes no

171 12p any abnormality
 yes no

172 Complex - ≥ 3 distinct abnormalities
 yes no

173 Other abnormality
 yes no

174 Specify other abnormality: _____

175 Were tests for molecular markers performed (e.g. PCR)?
 yes no Unknown

176 Date sample collected: ____ - ____ - ____

177 CEBPA
 Positive Negative Not Done

178 FLT3 – D835 point mutation
 Positive Negative Not Done

179 FLT3 – ITD mutation
 Positive Negative Not Done

180 IDH1
 Positive Negative Not Done

181 IDH2
 Positive Negative Not Done

182 KIT
 Positive Negative Not Done

183 NPM1
 Positive Negative Not Done

Other Molecular Marker (1) **Questions: 184 - 185**

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Center: _____ CRID: _____

184 Other molecular marker

Positive Negative Not Done

185 Specify other molecular marker: _____

186 Was flow cytometry performed?

yes no Unknown

Specify tissue and results at last evaluation prior to the start of the preparative regimen:

187 Blood

yes no

188 Date sample collected: ____-____-____

189 Was disease detected?

yes no

190 Bone marrow

yes no

191 Date sample collected: ____-____-____

192 Was disease detected?

yes no

Disease Status at the Last Evaluation Prior to the Start of the Preparative Regimen (Conditioning) Questions: 193 - 201

193 What was the disease status (based on hematological test results)? _____

Specify which of the following showed active leukemia at last evaluation prior to the start of the preparative regimen:

194 Blood

yes no Unknown

195 Bone marrow

yes no Unknown

196 Central nervous system

yes no Unknown

197 Skin

yes no Unknown

198 Testes

yes no Unknown

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Today's Date:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Infusion Date:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CIBMTR Center Number:	<input type="text"/>
Month	Day	Year	Month	Day	Year

Form 2010 R3.0: Acute Myelogenous Leukemia (AML) Pre-HCT Data

Center: _____ CRID: _____

199 Other site

yes no Unknown

200 Specify other site: _____

201 Date assessed: ____ - ____ - ____

First Name: _____

Last Name: _____

E-mail address: _____

Date: ____ - ____ - ____

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