ERROR CORRECTION FORM

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

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

Initials: | |

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

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

CIBMTR Center Number: | | | | | |

CIBMTR
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Immune Deficiencies Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: | | | | | |

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

Has this patient's data been previously reported to USIDNET?

1 ☐ yes → USIDNET ID: | | | | | | | | | | |
2 ☐ no

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

Date of HSCT for which this form is being completed: 🕮 Month | | Day | | | Year 2 0 | | |

HSCT type: ☐ autologous ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: ☐ marrow ☐ PBSC ☐ cord blood ☐ other product, specify: _____

This form must be accompanied by Form 2000 – Recipient Baseline Data. All information in the box above, including the date, should be identical with the corresponding Form 2000. Information should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HSCT, or abstraction of the recipient's medical records.

Questions followed by the symbol 🕮 indicate additional information necessary to complete the question is referenced in the forms instruction manual.

If this is a report of a second or subsequent transplant, check here ☐ and continue with question 128.

Disease Assessment at Diagnosis 🕮

Disease assessment at diagnosis includes disease characteristics observed within six weeks of the date of diagnosis.

1. What was the date of diagnosis of Immune Deficiency (ID)? Month | | Day | | | Year | | | |

2. What is the immune deficiency molecular abnormality?
   1 ☐ common gamma chain (γ_C; CD132) deficiency
   2 ☐ adenosine deaminase (ADA) deficiency
   3 ☐ Janus kinase 3 (JAK3) deficiency
   4 ☐ recombination-activating gene 1 (RAG1) deficiency
   5 ☐ recombination-activating gene 2 (RAG2) deficiency
   6 ☐ IL-7Rα deficiency
   7 ☐ DNA cross-link repair 1C (DCLRE1C) / Artemis deficiency
   8 ☐ CD3γ (gamma) deficiency
   9 ☐ CD3δ (delta) deficiency
   10 ☐ CD3ε (epsilon) deficiency
   11 ☐ CD3ζ (zeta)-chain deficiency
   12 ☐ zeta-chain (TCR) associated protein kinase 70 kDa (ZAP-70) deficiency
   13 ☐ CD25 deficiency
   14 ☐ CD45 deficiency
   15 ☐ purine nucleoside phosphorylase (PNP) deficiency
   16 ☐ Cernunnos-XLF / NHEJ1 deficiency
   17 ☐ DNA ligase 4 deficiency
   18 ☐ DNA-protein kinase catalytic subunit (DNA-PKcs) deficiency
   19 ☐ adenylate kinase 2 (AK2) deficiency (reticular dysgenesis)
   20 ☐ Omenn syndrome → 3. Specify molecular abnormality: _____
   21 ☐ bare lymphocyte syndrome (MHC class II) deficiency
   22 ☐ cartilage-hair hypoplasia (CHH) / metaphyseal dysplasia, McKusick type
   23 ☐ Orai1 deficiency
   24 ☐ other molecular abnormality → 4. Specify other abnormality: _____
   25 ☐ unknown

Internal use: Document number F00534 revision 2 Replaces: F00534 version 1.0 July 2007

Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).

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5. Is the mutated protein or enzyme expressed?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown
6. What is the pattern of inheritance for the genetic disorder?
   1 ☐ sporadic (no family history)
   2 ☐ x-linked, documented
   3 ☐ autosomal recessive, documented
   4 ☐ unknown
7. Are the parents of the patient consanguineous (related by blood ancestry)?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown
8. Are there other blood relatives in the patient's family with immunodeficiency disease?
   1 ☐ yes
   2 ☐ no
   3 ☐ unknown

Laboratory Studies at Diagnosis

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

9. Date CBC tested: Month | | Day | | | 2 0 | | | Year (testing done within 6 weeks of diagnosis)

Specify units:

10. WBC: | | | | | | | • | | 1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L ☐ not tested
11. Lymphocytes: | | % ☐ not tested
12. Eosinophils: | | % ☐ not tested
13. Polymorphonuclear leukocytes (PMN): | | % ☐ not tested
14. Hemoglobin: | | | | | • | | 1 ☐ g/dL 2 ☐ g/L 3 ☐ mmol/L ☐ not tested ☐ transfused RBC < 30 days from date of test
15. Platelets: | | | | | | | | 1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L ☐ not tested ☐ transfused platelets < 7 days from date of test

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

CIBMTR Center Number: | CIBMTR Recipient ID:

Immunoglobulin Analysis

Specify the following quantitative immunoglobulins measured prior to any disease treatment:

	Value:	Specify units:	Date tested: Month Day Year	
16. IgG:	____ • __	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	17.	☐ not tested
18. IgM:	____ • __	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	19.	☐ not tested
20. IgA:	____ • __	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	21.	☐ not tested
22. IgE:	___ IU/mL		23.	☐ not tested

24. Did the recipient receive supplemental intravenous immunoglobulins (IVIG) prior to any first treatment of ID?
   1 ☐ yes → 25. Was therapy ongoing within one month of immunoglobulin testing? 1 ☐ yes 2 ☐ no
   2 ☐ no
   3 ☐ unknown

Lymphocyte Analysis

Specify the following lymphocyte analyses performed prior to any disease treatment:

26. Were lymphocyte analyses performed? 🕮
   1 ☐ yes →
   2 ☐ no

27. Date of most recent testing performed: Month Day Year

28. Absolute lymphocyte count: → ____ cells / µL (cells / mm^3)

	% of total lymphocytes:		Value:	Specify units:	
29. CD3 (T cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
30. CD4 (T helper cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
31. CD8 (cytotoxic T cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
32. CD20 (B lymphocyte cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
33. CD56 (natural killer (NK) cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
34. CD4+ / CD45RA+ (naive T cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
35. CD4+ / CD45RO+ (memory T cells): →	__	– or –	____	1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested

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Antibody Response

36. Date antibody responses were assessed: Month | | Day | | Year 2 0 | | *(date closest to diagnosis, before any IVIG)*

Absent	Low	Normal	Not tested	
1 ☐	2 ☐	3 ☐	4 ☐	37. Bacteriophage phi X-174 or other neoantigen
1 ☐	2 ☐	3 ☐	4 ☐	38. Diptheria
1 ☐	2 ☐	3 ☐	4 ☐	39. Isohemagglutinin anti-A
1 ☐	2 ☐	3 ☐	4 ☐	40. Isohemagglutinin anti-B
1 ☐	2 ☐	3 ☐	4 ☐	41. Protein conjugated HIB or pneumococcal vaccine
1 ☐	2 ☐	3 ☐	4 ☐	42. Tetanus

43. Unconjugated pneumococcal polysaccharide: | | / | |

Number of serotypes producing a protective level / Total serotypes tested from vaccine

Lymphocyte Function

44. Date lymphocyte function was assessed: Month | | Day | | Year 2 0 | |

Absent (< 10% of control)	Low (10-30% of control)	Normal (> 30% of control)	Not tested	
1 ☐	2 ☐	3 ☐	4 ☐	45. Anti-CD3
1 ☐	2 ☐	3 ☐	4 ☐	46. Candida antigen
1 ☐	2 ☐	3 ☐	4 ☐	47. Concavalin A (ConA)
1 ☐	2 ☐	3 ☐	4 ☐	48. Phytohemagglutinin (PHA)
1 ☐	2 ☐	3 ☐	4 ☐	49. Pokeweed mitogen (PWM)
1 ☐	2 ☐	3 ☐	4 ☐	50. Tetanus antigen

Clinical Features Assessed between Diagnosis and the Start of the Preparative Regimen

Infections Identified between Diagnosis and the Start of the Preparative Regimen

Specify the presence of all clinically significant infections identified between diagnosis and the start of the preparative regimen. If any given infection was identified, use the Codes for Commonly Reported Organisms on the following page to report the organism present. Only report an organism once, even if it was identified at the same site in subsequent infections.
For questions 75–87, also report any fungal infections in the Form 2000 – Recipient Baseline Data beginning at question 163.

Copy this chart to report more than three different infections identified at any one site; check here ☐ if additional pages are attached.

Site of infection?		First organism	Second organism	Third organism	Specify other organism
51. 1 ☐ yes 2 ☐ no	Hepatitis → 52.	53.	54.		55. _____
56. If hepatitis was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					
57. 1 ☐ yes 2 ☐ no	Meningitis / encephalitis → 58.	59.	60.		61. _____
62. If meningitis / encephalitis was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					
63. 1 ☐ yes 2 ☐ no	Pneumonia → 64.	65.	66.		67. _____
68. If pneumonia was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					

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Site of infection?		First organism	Second organism	Third organism	Specify other organism
69. 1 ☐ yes 2 ☐ no	Severe or protracted diarrhea ➔ 70.		71.	72.	73. _____
74. If diarrhea was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					
75. 1 ☐ yes 2 ☐ no	Systemic infection ——➔ 76.		77.	78.	79. _____
80. If systemic infection was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					
81. 1 ☐ yes 2 ☐ no	Other infection ——➔ 82.		83.	84.	85. _____
86. Specify other infection site: _____					
87. If other infection was present, was it a prominent feature of ID? 1 ☐ yes 2 ☐ no					

Codes for Commonly Reported Organisms

Bacterial Infections

121 Acinetobacter
122 Actinomyces
123 Bacillus
124 Bacteroides (gracillis, uniformis, vulgaris, other species)
125 Bordetella pertussis (whooping cough)
126 Borrelia (Lyme disease)
127 Branhamella or Moraxella catarrhalis (other species)
128 Campylobacter (all species)
129 Capnocytophaga
171 Chlamydia pneumoniae
172 Other chlamydia, specify
113 Chlamydia, NOS
130 Citrobacter (freundii, other species)
131 Clostridium (all species except difficile)
132 Clostridium difficile
173 Corynebacterium jeikeium
133 Corynebacterium (all non-diptheria species)
101 Coxiella
134 Enterobacter
177 Enterococcus, vancomycin resistant (VRE)
135 Enterococcus (all species)
136 Escherichia (also E. coli)
137 Flavimonas oryzihabitans
138 Flavobacterium
139 Fusobacterium
144 Haemophilus (all species, including influenzae)
145 Helicobacter pylori
146 Klebsiella
147 Lactobacillus (bulgaricus, acidophilus, other species)
102 Legionella
103 Leptospira
148 Leptotrichia buccalis
149 Leuconostoc (all species)
104 Listeria
150 Methylobacterium
151 Micrococcus, NOS
112 Mycobacterium avium– intracellulare (MAC, MAI)
174 Mycobacterium species (cheloneae, fortuitum, haemophilum, kansasii, mucogenicum
110 Mycobacterium tuberculosis (tuberculosis, Koch bacillus)
175 Other mycobacterium, specify
176 Mycobacterium, NOS
105 Mycoplasma
152 Neisseria (gonorrhoea, meningitidis, other species)
106 Nocardia
153 Pasteurella multocida
154 Propionibacterium (acnes, avidum, granulosum, other species)
155 Proteus
156 Pseudomonas (all species except cepacia & maltophilia)
157 Pseudomonas or Burkholderia cepacia
158 Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
159 Rhodococcus
107 Rickettsia
160 Salmonella (all species)
161 Serratia marcescens
162 Shigella
163 Staphylococcus, coagulase negative (not aureus)
164 Staphylococcus aureus
165 Staphylococcus, NOS
166 Stomatococcus mucilaginosis
167 Streptococcus (all species except Enterococcus)
178 Streptococcus pneumoniae
168 Treponema (syphilis)
169 Vibrio (all species)
197 Multiple bacteria at a single site, specify bacterial codes
198 Other bacteria, specify ‡
501 Suspected atypical bacterial infection
502 Suspected bacterial infection

Fungal Infections

200 Candida, NOS
201 Candida albicans
206 Candida guillermondi
202 Candida krusei
207 Candida lusitaniae
203 Candida parapsilosis
204 Candida tropicalis
205 Candida (Torulopsis) glabrata
209 Other Candida, specify ‡
210 Aspergillus, NOS §
211 Aspergillus flavus §
212 Aspergillus fumigatus §
213 Aspergillus niger §
219 Other Aspergillus, specify ‡ §
220 Cryptococcus species
230 Fusarium species §
261 Histoplasmosis
240 Zygomycetes, NOS §
241 Mucormycosis §
242 Rhizopus §
250 Yeast, NOS
259 Other fungus, specify ‡
260 Pneumocystis (PCP / PJP)
503 Suspected fungal infection

Viral Infections

301 Herpes simplex (HSV1, HSV2)
302 Varicella (herpes zoster, chicken pox)
303 Cytomegalovirus (CMV)
304 Adenovirus
305 Enterovirus (coxsackie, echo, polio)
306 Hepatitis A (HAV)
307 Hepatitis B (HBV, Australian antigen) †
308 Hepatitis C (HCV) †
309 HIV-1 (HTLV-III) ¤
310 Influenza, NOS
323 Influenza A
324 Influenza B
311 Measles (rubeola)
312 Mumps
313 Progressive multifocal leukoencephalopathy (PML)
314 Respiratory syncytial virus (RSV)
315 Rubella (German measles)
316 Parainfluenza
317 Human herpesvirus-6 (HHV-6)
318 Epstein-Barr virus (EBV)
319 Polyoma virus (BK virus, JC virus)
320 Rotavirus
321 Rhinovirus
322 Human papilloma virus (HPV)
329 Other virus, specify ‡
504 Suspected viral infection

Parasitic Infections

402 Toxoplasma
403 Giardia
404 Cryptosporidium
409 Other parasite, specify ‡
505 Suspected parasite infection

Other Infections

509 No organism identified

‡ The codes for "other organism, specify" (codes 198, 209, 219, 259, 329 and 409) should rarely be needed; check with your microbiology lab or HSCT physician before using them.

§ For fungal infections marked with a section symbol (codes 210, 211, 212, 213, 219, 230, 240, 241, and 242), also complete a Fungal Infection (FNG) form.

† For hepatitis infections marked with a dagger symbol (codes 307 and 308), also complete a Hepatitis (HEP) form.

¤ For HIV infections marked with a currency symbol (code 309), also complete an HIV Infection (HIV) form.

* Do not report fever in the absence of infection. Report the most specific site of infection.

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Clinical Status between Diagnosis and the Preparative Regimen

88. Did the recipient experience any of the following clinical features (between diagnosis and prior to the preparative regimen)?

1 ☐ yes → Specify clinical features:

2 ☐ no

	Feature present?			If present, is the feature prominent?	
89.	1 ☐ yes 2 ☐ no	Autoimmune hemolytic anemia →	90.	1 ☐ yes	2 ☐ no
91.	1 ☐ yes 2 ☐ no	Bone abnormalities →	92.	1 ☐ yes	2 ☐ no
93.	1 ☐ yes 2 ☐ no	Edema →	94.	1 ☐ yes	2 ☐ no
95.	1 ☐ yes 2 ☐ no	Eosinophilia →	96.	1 ☐ yes	2 ☐ no
97.	1 ☐ yes 2 ☐ no	Failure to thrive (weight < 5th percentile) →	98.	1 ☐ yes	2 ☐ no
99.	1 ☐ yes 2 ☐ no	Graft versus host disease due to blood transfusion →	100.	1 ☐ yes	2 ☐ no
101.	1 ☐ yes 2 ☐ no	Graft versus host disease due to maternal engraftment →	102.	1 ☐ yes	2 ☐ no
103.	1 ☐ yes 2 ☐ no	Growth hormone deficiency →	104.	1 ☐ yes	2 ☐ no
105.	1 ☐ yes 2 ☐ no	Growth retardation (height < 5th percentile) →	106.	1 ☐ yes	2 ☐ no
107.	1 ☐ yes 2 ☐ no	Hepatosplenomegaly →	108.	1 ☐ yes	2 ☐ no
109.	1 ☐ yes 2 ☐ no	Hypoproteinemia →	110.	1 ☐ yes	2 ☐ no
111.	1 ☐ yes 2 ☐ no	Lymphoproliferative disease →	112.	1 ☐ yes	2 ☐ no
113.	1 ☐ yes 2 ☐ no	Maternal T-cell engraftment →	114.	1 ☐ yes	2 ☐ no
115.	1 ☐ yes 2 ☐ no	Microcephaly →	116.	1 ☐ yes	2 ☐ no
117.	1 ☐ yes 2 ☐ no	Neutropenia →	118.	1 ☐ yes	2 ☐ no
119.	1 ☐ yes 2 ☐ no	Skin rash →	120.	1 ☐ yes	2 ☐ no
121.	1 ☐ yes 2 ☐ no	Thrombocytopenia (< 100 x 10^9/L) →	122.	1 ☐ yes	2 ☐ no
123.	1 ☐ yes 2 ☐ no	Warts →	124.	1 ☐ yes	2 ☐ no
125.	1 ☐ yes 2 ☐ no	Other features →	126.	1 ☐ yes	2 ☐ no

127. Specify other features: _____

Pre-HSCT Treatment for Immune Deficiency

128. Was treatment given (between diagnosis and prior to the preparative regimen)?

1 ☐ yes → **Complete the table below**

2 ☐ no → **Continue with question 188**

Prophylactic drugs paused for < 1 week should *not* be considered as "Prophylactic Drug Stopped."

	Prophylactic Drug Given?	Prophylactic Drug Stopped?	Date Stopped (Month / Day / Year)	
129. Antifungal drug(s)	1 ☐ yes 2 ☐ no	130. 1 ☐ yes 2 ☐ no	131.	☐ date estimated ☐ date unknown
132. Antiviral drug(s)	1 ☐ yes 2 ☐ no	133. 1 ☐ yes 2 ☐ no	134.	☐ date estimated ☐ date unknown
135. Co-trimoxazole (Bactrim, Septra)	1 ☐ yes 2 ☐ no	136. 1 ☐ yes 2 ☐ no	137.	☐ date estimated ☐ date unknown

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Therapy paused for < 1 week should *not* be considered as "Therapy Stopped."

	Therapy Given?	Therapy Stopped?	Date Stopped (Month / Day / Year)	
138. Antithymocyte globulin (ATG, ATGAM, Thymoglobulin)	1 ☐ yes → 139. / 2 ☐ no	1 ☐ yes → 140. / 2 ☐ no		☐ date estimated ☐ date unknown
141. Corticosteroids, systemic	1 ☐ yes → 142. / 2 ☐ no	1 ☐ yes → 143. / 2 ☐ no		☐ date estimated ☐ date unknown
144. Corticosteroids, topical	1 ☐ yes → 145. / 2 ☐ no	1 ☐ yes → 146. / 2 ☐ no		☐ date estimated ☐ date unknown
147. Cyclophosphamide (CTX, Cytoxan, Neosar)	1 ☐ yes → 148. / 2 ☐ no	1 ☐ yes → 149. / 2 ☐ no		☐ date estimated ☐ date unknown
150. Cyclosporine (CsA, Neoral, Sandimmune)	1 ☐ yes → 151. / 2 ☐ no	1 ☐ yes → 152. / 2 ☐ no		☐ date estimated ☐ date unknown
153. In vivo monoclonal antibody	1 ☐ yes → / 2 ☐ no			

Specify monoclonal antibody:

	Therapy Given?	Therapy Stopped?	Date Stopped (Month / Day / Year)	
154. Alemtuzumab (Campath)	1 ☐ yes → 155. / 2 ☐ no	1 ☐ yes → 156. / 2 ☐ no		☐ date estimated ☐ date unknown
157. Daclizumab (anti-CD25, Zenapax)	1 ☐ yes → 158. / 2 ☐ no	1 ☐ yes → 159. / 2 ☐ no		☐ date estimated ☐ date unknown
160. Etanercept (Enbrel)	1 ☐ yes → 161. / 2 ☐ no	1 ☐ yes → 162. / 2 ☐ no		☐ date estimated ☐ date unknown
163. Infliximab (anti-TNF-α, Remicade)	1 ☐ yes → 164. / 2 ☐ no	1 ☐ yes → 165. / 2 ☐ no		☐ date estimated ☐ date unknown
166. Rituximab (anti-CD20, Rituxan, MabThera)	1 ☐ yes → 167. / 2 ☐ no	1 ☐ yes → 168. / 2 ☐ no		☐ date estimated ☐ date unknown
169. Other monoclonal antibody	1 ☐ yes → 170. / 2 ☐ no	1 ☐ yes → 171. / 2 ☐ no		☐ date estimated ☐ date unknown

172. Specify other monoclonal antibody: _____

173. Mycophenolate mofetil (MMF, Cellcept)	1 ☐ yes → 174. / 2 ☐ no	1 ☐ yes → 175. / 2 ☐ no		☐ date estimated ☐ date unknown
176. Tacrolimus (FK506, Prograf)	1 ☐ yes → 177. / 2 ☐ no	1 ☐ yes → 178. / 2 ☐ no		☐ date estimated ☐ date unknown

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Therapy Given? **Therapy Stopped?** **Date Stopped**

179. Other immunosuppressive drug
1 ☐ yes → 180. 1 ☐ yes → 181. Month | | Day | | | 2 0 | | | Year ☐ date estimated ☐ date unknown
2 ☐ no 2 ☐ no

182. Specify other immunosuppressive drug: _____

183. Was gene therapy performed (between diagnosis and prior to the preparative regimen)?
1 ☐ yes →
2 ☐ no

184. Specify date of infusion of gene therapy: Month | | Day | | | 2 0 | | | Year

185. Was the recipient considered to have failed gene therapy?
1 ☐ yes
2 ☐ no

186. Did the recipient receive any other significant treatment(s) (between diagnosis and prior to the preparative regimen)?
1 ☐ yes →
2 ☐ no

187. Specify other treatment(s): _____

188. Did the patient receive parenteral nutrition (between diagnosis and prior to the preparative regimen)?
1 ☐ yes
2 ☐ no

189. Did the patient receive mechanical ventilation (between diagnosis and prior to the preparative regimen)?
1 ☐ yes
2 ☐ no

190. Were any biologic specimens collected for this recipient (between diagnosis and prior to the preparative regimen)?
1 ☐ yes →
2 ☐ no
3 ☐ unknown

Specify if specimen(s) collected and available for future research:

191. 1 ☐ yes 2 ☐ no DNA
192. 1 ☐ yes 2 ☐ no Epstein-Barr virus (EBV)-transformed B-cell line
193. 1 ☐ yes 2 ☐ no Fibroblast cell line
194. 1 ☐ yes 2 ☐ no Herpes virus saimiri-transformed T-cell line
195. 1 ☐ yes 2 ☐ no Other T-cell line
196. 1 ☐ yes 2 ☐ no Pathological specimen → 197. Specify pathological specimen(s): _____
198. 1 ☐ yes 2 ☐ no Peripheral blood mononuclear cells (PBMC), frozen
199. 1 ☐ yes 2 ☐ no RNA → 200. Specify RNA source: _____
201. 1 ☐ yes 2 ☐ no Serum (pre-IVIG)
202. 1 ☐ yes 2 ☐ no Other specimen → 203. Specify other specimen(s): _____

204. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

Internal use: Document number F00534 revision 2 Replaces: F00534 version 1.0 July 2007

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).