**ERROR CORRECTION FORM**

Sequence Number: CIBMTR Recipient ID: Initials:

Today's Date: Infusion Date: CIBMTR Center Number:

Month Day Year Month Day Year

---

**2031: Immune Deficiencies Pre-HSCT Data**

Registry Use Only
Sequence Number:

Date Received:

---

### Key Fields

| Sequence Number: |  __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ____
**CIBMTR Center Number:**

**HSCT type:** (check all that apply)
- Autologous
  - ELSE GOTO Allogeneic, unrelated
- Allogeneic, unrelated
  - ELSE GOTO Allogeneic, related
- Allogeneic, related
  - ELSE GOTO Syngeneic (identical twin)
- Syngeneic (identical twin)
  - ELSE GOTO Marrow

**Product type:** (check all that apply)
- Marrow
  - ELSE GOTO PBSC
- PBSC
  - ELSE GOTO Cord blood
- Cord blood
  - ELSE GOTO Other product
- Other product
  - IF Other product:= checked
    - THEN GOTO Specify:
    - ELSE GOTO Marrow

**Disease Assessment at Diagnosis**

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.

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

---

**Questions: 1-8**

- If this is a report of a second or subsequent transplant, check here. Continue with question 116.
- IF This is a report of a second or subsequent transplant, check here.:= checked
  - THEN GOTO (116) Was treatment given (between diagnosis and prior to the preparative regimen)?
  - ELSE GOTO (1) What was the date of diagnosis of Immune Deficiency (ID)?
1. What was the date of diagnosis of Immune Deficiency (ID)?

   ELSE GOTO (2) What is the immune deficiency molecular abnormality?

2. What is the immune deficiency molecular abnormality?
   - common gamma chain (γc; CD132) deficiency
   - adenosine deaminase (ADA) deficiency
   - Janus kinase 3 (JAK3) deficiency
   - recombination-activating gene 1 (RAG1) deficiency
   - recombination-activating gene 2 (RAG2) deficiency
   - IL-7Rα deficiency
   - DNA cross-link repair 1C (DCLRE1C) / Artemis deficiency
   - CD3γ (gamma) deficiency
   - CD3δ (delta) deficiency
   - CD3ε (epsilon) deficiency
   - CD3ζ (zeta) deficiency
   - zeta-chain (TCR) associated protein kinase 70 kDa (ZAP-70) deficiency
   - CD25 deficiency
   - DNA ligase 4 deficiency
   - DNA-protein kinase catalytic subunit (DNA-PKcs) deficiency
   - adenylyl kinase 2 (AK2) deficiency (reticular dysgenesis)
CIBMTR Center Number: __________________________ CIBMTR Recipient ID: __________________________

- Omenn syndrome
- bare lymphocyte syndrome (MCH class II) deficiency
- cartilage-hair hypoplasia (CHH) / metaphyseal dysplasia, McKusick type
- Orai1 deficiency
- other molecular abnormality
- unknown

**IF (2) What is the immune deficiency molecular abnormality?:**

- Omenn syndrome

**THEN GOTO (3) Specify molecular abnormality:**

**ELSE GOTO (5) Is the mutated protein or enzyme expressed?**

**IF (2) What is the immune deficiency molecular abnormality?:**

- other molecular abnormality

**THEN GOTO (4) Specify other abnormality:**

**ELSE GOTO (5) Is the mutated protein or enzyme expressed?**

3 Specify molecular abnormality: __________________________

**ELSE GOTO (4) Specify other abnormality:**

4 Specify other abnormality: __________________________

**ELSE GOTO (5) Is the mutated protein or enzyme expressed?**

5 Is the mutated protein or enzyme expressed?

- yes
- no
- unknown

**ELSE GOTO (6) What is the pattern of inheritance for the genetic disorder?**

6 What is the pattern of inheritance for the genetic disorder?

- sporadic (no family history)
- x-linked, documented
- autosomal recessive, documented
- unknown

**ELSE GOTO (7) Are the parents of the patient consanguineous (related by blood ancestry)?**

7 Are the parents of the patient consanguineous (related by blood ancestry)?

- yes
- no
- unknown

**ELSE GOTO (8) Are there other blood relatives in the patient's family with immunodeficiency disease?**

8 Are there other blood relatives in the patient's family with immunodeficiency disease?

- yes
- no
- unknown

**ELSE GOTO (9) Date CBC tested: (testing done within 6 weeks of diagnosis)**

<table>
<thead>
<tr>
<th>Laboratory Studies at Diagnosis</th>
<th>Questions: 9-50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report findings prior to any first treatment of the primary disease for which the HSCT is being performed.</td>
<td></td>
</tr>
<tr>
<td>9 Date CBC tested: (testing done within 6 weeks of diagnosis)</td>
<td></td>
</tr>
</tbody>
</table>

CIBMTR Form 2031 revision 3 (page 4 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

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).
ELSE GOTO (10) WBC not tested

10 □ WBC not tested
   IF (10) WBC not tested:= checked
   THEN GOTO (11) Lymphocytes not tested
   ELSE GOTO WBC:
      WBC: _______ • _______ O x 10^9/L (x 10^9/mm^3)
      ELSE GOTO Specify unit of measure O x 10^9/L
      ELSE GOTO (11) Lymphocytes not tested

11 □ Lymphocytes not tested
   IF (11) Lymphocytes not tested:= checked
   THEN GOTO (12) Eosinophils not tested
   ELSE GOTO Lymphocytes:
      Lymphocytes: ______________ %
      ELSE GOTO (12) Eosinophils not tested

12 □ Eosinophils not tested
   IF (12) Eosinophils not tested:= checked
   THEN GOTO (13) Polymorphonuclear leukocytes (PMN) not tested
   ELSE GOTO Eosinophils:
      Eosinophils: ______________ %
      ELSE GOTO (13) Polymorphonuclear leukocytes (PMN) not tested

13 □ Polymorphonuclear leukocytes (PMN) not tested
   IF (13) Polymorphonuclear leukocytes (PMN) not tested:= checked
   THEN GOTO (14) Hemoglobin not tested
   ELSE GOTO Polymorphonuclear leukocytes (PMN):
      Polymorphonuclear leukocytes ______ ______ ______ ______ %
      (PMN):
      ELSE GOTO (14) Hemoglobin not tested

14 □ Hemoglobin not tested
   IF (14) Hemoglobin not tested:= checked
   THEN GOTO (15) Platelets not tested
   ELSE GOTO Hemoglobin:
      Hemoglobin: _______ • _______ O g/dL
      ELSE GOTO Specify unit of measure O g/L
      ELSE GOTO mmol/L
      ELSE GOTO transfused RBC < 30 days from date of test

   ELSE GOTO transfused RBC < 30 days from date of test
   ELSE GOTO (15) Platelets not tested

15 □ Platelets not tested
   IF (15) Platelets not tested:= checked
   THEN GOTO (16) IgG not tested
   ELSE GOTO Platelets:
      Platelets: ______ ______ ______ ______ ______
      ELSE GOTO (16) IgG not tested

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).
ERROR CORRECTION FORM

CIBMTR Center Number: ____________  CIBMTR Recipient ID: ________________

Date of infusion: __________
Month  __  Day  __  Year  __

Platelets:  _____  _____  _____  _____  _____  _____  _____  
ELSE GOTO Platelets:

ELSE GOTO Specify unit of measure

O  x 10^9/L (x 10^9/mm^3)
O  x 10^6/L
ELSE GOTO transfused platelets < 7 days from date of test

transfused platelets < 7 days from date of test
ELSE GOTO (16) IgG not tested

16  □ IgG not tested

IF (16) IgG not tested := checked
THEN GOTO (18) IgM not tested
ELSE GOTO IgG:

IgG:  _____  _____  _____  _____  •  __________
ELSE GOTO Specify unit of measure

O  mg/dL
O  g/dL
O  g/L
ELSE GOTO (17) IgG date tested

17  Date tested:  --  YYYY  --  MM  --  DD  --
ELSE GOTO (18) IgM not tested

ELSE GOTO (17) IgG date tested

18  □ IgM not tested

IF (18) IgM not tested := checked
THEN GOTO (20) IgA not tested
ELSE GOTO IgM:

IgM:  _____  _____  •  ______
ELSE GOTO Specify unit of measure

O  mg/dL
O  g/dL
O  g/L
ELSE GOTO (19) IgM date tested

19  Date tested:  --  YYYY  --  MM  --  DD  --
ELSE GOTO (20) IgA not tested

ELSE GOTO (19) IgM date tested

ELSE GOTO (18) IgM not tested

20  □ IgA not tested

IF (20) IgA not tested := checked
THEN GOTO (22) IgE not tested
ELSE GOTO IgA:

IgA:  _____  •  ______
ELSE GOTO Specify unit of measure

O  mg/dL
O  g/dL
O  g/L
ELSE GOTO (21) IgA date tested

21  Date tested:  --  --  --  --

CIBMTR Form 2031 revision 3 (page 6 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and
The Medical College of Wisconsin, Inc. All rights reserved.

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).
ELSE GOTO (22) IgE not tested

22 □ IgE not tested
   IF (22) IgE not tested:= checked
       THEN GOTO (24) Did the recipient receive supplemental intravenous immunoglobulins (IVIG) prior to any first treatment of ID?
       ELSE GOTO IgE:

IgE: __________ IU/mL
ELSE GOTO (23) IgE date tested

23 Date tested: _____-____-____
   ELSE GOTO (24) Did the recipient receive supplemental intravenous immunoglobulins (IVIG) prior to any first treatment of ID?

24 Did the recipient receive supplemental intravenous immunoglobulins (IVIG) prior to any first treatment of ID?
   O yes
   O no
   O unknown

   IF (24) Did the recipient receive supplemental intravenous immunoglobulins (IVIG) prior to any first treatment of ID?:= yes
       THEN GOTO (25) Was therapy ongoing within one month of immunoglobulin testing?
       ELSE GOTO (26) Were lymphocyte analyses performed?

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

25 Was therapy ongoing within one month of immunoglobulin testing?
   O yes
   O no

   ELSE GOTO (26) Were lymphocyte analyses performed?

26 Were lymphocyte analyses performed?
   O yes
   O no

   IF (26) Were lymphocyte analyses performed?:= no
       THEN GOTO (36) Date antibody responses were assessed: (date closest to diagnosis, before any IVIG)
       ELSE GOTO (27) Date of most recent testing performed:

27 Date of most recent testing performed: _____-____-____
   ELSE GOTO (28) Absolute lymphocyte count:

28 Absolute lymphocyte count: __________ cells / uL (cells / (mm)**3)
### CIBMTR Form 2031 Revision 3 (page 8 of 50) Last Updated November 29, 2012.

Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

---

**CIBMTR Center Number:** ____________  
**CIBMTR Recipient ID:** ____________

---

**CD3 (T cells) not tested**

<table>
<thead>
<tr>
<th>29</th>
<th>CD3 (T cells) not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IF (29) CD3 (T cells) not tested:= checked</td>
</tr>
<tr>
<td></td>
<td>THEN GOTO (30) CD4 (T helper cells) not tested</td>
</tr>
<tr>
<td></td>
<td>ELSE GOTO percent of CD3 (T cells)</td>
</tr>
</tbody>
</table>

CD3 (T cells) % of total lymphocytes _________________  %

IF percent of CD3 (T cells):= EXISTS  
THEN GOTO (30) CD4 (T helper cells) not tested  
ELSE GOTO Value of CD3 (T cells)  

---

-- or --

<table>
<thead>
<tr>
<th>CD3 (T cells) value ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>O x 10^9/L (x 10^9/mm^3)</td>
</tr>
</tbody>
</table>

ELSE GOTO Specify unit of measure  

O x 10^9/L  

ELSE GOTO (30) CD4 (T helper cells) not tested  

---

**CD4 (T helper cells) not tested**

<table>
<thead>
<tr>
<th>30</th>
<th>CD4 (T helper cells) not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IF (30) CD4 (T helper cells) not tested:= checked</td>
</tr>
<tr>
<td></td>
<td>THEN GOTO (31) CD8 (cytotoxic T cells) not tested</td>
</tr>
<tr>
<td></td>
<td>ELSE GOTO percent of CD4 (T helper cells)</td>
</tr>
</tbody>
</table>

CD4 (T helper cells) % of total lymphocytes _________________  %

IF percent of CD4 (T helper cells):= EXISTS  
THEN GOTO (31) CD8 (cytotoxic T cells) not tested  
ELSE GOTO Value of CD4 (T helper cells)  

---

-- or --

<table>
<thead>
<tr>
<th>CD4 (T helper cells) value ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>O x 10^9/L (x 10^9/mm^3)</td>
</tr>
</tbody>
</table>

ELSE GOTO Specify unit of measure  

O x 10^9/L  

ELSE GOTO (31) CD8 (cytotoxic T cells) not tested  

---

**CD8 (cytotoxic T cells) not tested**

<table>
<thead>
<tr>
<th>31</th>
<th>CD8 (cytotoxic T cells) not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IF (31) CD8 (cytotoxic T cells) not tested:= checked</td>
</tr>
<tr>
<td></td>
<td>THEN GOTO (32) CD20 (B lymphocyte cells) not tested</td>
</tr>
<tr>
<td></td>
<td>ELSE GOTO percent of CD8 (cytotoxic T cells)</td>
</tr>
</tbody>
</table>

CD8 (cytotoxic T cells) % of total lymphocytes _________________  %

IF percent of CD8 (cytotoxic T cells):= EXISTS  
THEN GOTO (32) CD20 (B lymphocyte cells) not tested  
ELSE GOTO Value of CD8 (cytotoxic T cells)  

---

-- or --

<table>
<thead>
<tr>
<th>CD8 (cytotoxic T cells) value ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>O x 10^9/L (x 10^9/mm^3)</td>
</tr>
</tbody>
</table>

ELSE GOTO Specify unit of measure  

O x 10^9/L  

---

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).
CIBMTR Center Number: __________________
CIBMTR Recipient ID: ________________________

ELSE GOTO (32) CD20 (B lymphocyte cells) not tested

32  ☐ CD20 (B lymphocyte cells) not tested
   IF (32) CD20 (B lymphocyte cells) not tested:= checked
   THEN GOTO (33) CD56 (natural killer (NK) cells) not tested
   ELSE GOTO percent of CD20 (B lymphocyte cells)

   CD20 (B lymphocyte cells) % of total lymphocytes ________________ %
   IF percent of CD20 (B lymphocyte cells):= EXISTS
   THEN GOTO (33) CD56 (natural killer (NK) cells) not tested
   ELSE GOTO Value of CD20 (B lymphocyte cells)

   -- or --
   CD20 (B lymphocyte cells) value ____________
   ELSE GOTO Specify unit of measure

   O x 10⁹/L (x 10⁹/mm³)
   O x 10⁶/L
   ELSE GOTO (33) CD56 (natural killer (NK) cells) not tested

33  ☐ CD56 (natural killer (NK) cells) not tested
   IF (33) CD56 (natural killer (NK) cells) not tested:= checked
   THEN GOTO (34) CD4+/CD45RA+ (memory T cells) not tested
   ELSE GOTO percent of CD56 (natural killer (NK) cells)

   CD56 (natural killer (NK) cells) % of total lymphocytes ________________ %
   IF percent of CD56 (natural killer (NK) cells):= EXISTS
   THEN GOTO (34) CD4+/CD45RA+ (memory T cells) not tested
   ELSE GOTO Value of CD56 (natural killer (NK) cells)

   -- or --
   CD56 (natural killer (NK) cells) value ____________
   ELSE GOTO Specify unit of measure

   O x 10⁹/L (x 10⁹/mm³)
   O x 10⁶/L
   ELSE GOTO (34) CD4+/CD45RA+ (memory T cells) not tested

34  ☐ CD4+/CD45RA+ (memory T cells) not tested
   IF (34) CD4+/CD45RA+ (memory T cells) not tested:= checked
   THEN GOTO (35) CD4+/CD45RO+ (memory T cells) not tested
   ELSE GOTO percent of CD4+ / CD45RA+ (naive T cells):

   CD4+/CD45RA+ (naive T cells) % of total lymphocytes ________________ %
   IF percent of CD4+ / CD45RA+ (naive T cells):= EXISTS
   THEN GOTO (35) CD4+/CD45RO+ (memory T cells) not tested
   ELSE GOTO Value of CD4+ / CD45RA+ (naive T cells)

   -- or --
   CD4+/CD45RA+ (naive T cells) value ____________
   ELSE GOTO Specify unit of measure

   O x 10⁹/L (x 10⁹/mm³)
   O x 10⁶/L
   ELSE GOTO (35) CD4+/CD45RO+ (memory T cells) not tested
35 ☐ CD4+/CD45RO+ (memory T cells) not tested
   IF (35) CD4+/CD45RO+ (memory T cells) not tested:= checked
   THEN GOTO (36) Date antibody responses were assessed: (date closest to diagnosis, before any IVIG)
   ELSE GOTO percent of CD4+ / CD45RO+ (memory T cells)

   CD4+/CD45RO+ (memory T cells) % of total lymphocytes __________________________ %
   IF percent of CD4+ / CD45RO+ (memory T cells):= EXISTS
   THEN GOTO (36) Date antibody responses were assessed: (date closest to diagnosis, before any IVIG)
   ELSE GOTO Value of CD4+ / CD45RO+ (memory T cells)

   -- or --
   CD4+/CD45RO+ (memory T cells) value
   O x 10^9/L (x 10^3/mm^3)
   O x 10^6/L

   ELSE GOTO Specify unit of measure
   ELSE GOTO (36) Date antibody responses were assessed: (date closest to diagnosis, before any IVIG)

   Antibody Response
36 Date antibody responses were assessed: (date closest to diagnosis, before any IVIG) -- YYYY -- MM -- DD --
   ELSE GOTO (37) Bacteriophage phi X-174 or other neoantigen

37 Bacteriophage phi X-174 or other neoantigen
   O Absent
   O Low
   O Normal
   O Not Tested
   ELSE GOTO (38) Diptheria

38 Diptheria
   O Absent
   O Low
   O Normal
   O Not Tested
   ELSE GOTO (39) Isohemagglutinin anti-A

39 Isohemagglutinin anti-A
   O Absent
   O Low
   O Normal
   O Not Tested
   ELSE GOTO (40) Isohemagglutinin anti-B

40 Isohemagglutinin anti-B
   O Absent
   O Low
   O Normal
   O Not Tested
ELSE GOTO (41) Protein conjugated HIB or pneumococcal vaccine

41 Protein conjugated HIB or pneumococcal vaccine
   O Absent
   O Low
   O Normal
   O Not Tested
   ELSE GOTO (42) Tetanus

42 Tetanus
   O Absent
   O Low
   O Normal
   O Not Tested
   ELSE GOTO (43) Number of serotypes

43 Unconjugated pneumococcal polysaccharide: / Number of serotypes producing a protective level / Total serotypes tested from vaccine
   ELSE GOTO Total serotypes

Lymphocyte Function
44 Date lymphocyte function was assessed: YYYY MM DD
   ELSE GOTO (45) Anti-CD3

45 Anti-CD3
   O Absent (<10% of control)
   O Low (10-30% of control)
   O Normal (>30% of control)
   O Not Tested
   ELSE GOTO (46) Candida antigen

46 Candida antigen
   O Absent (<10% of control)
   O Low (10-30% of control)
   O Normal (>30% of control)
   O Not Tested
   ELSE GOTO (47) Concavalin A (ConA)

47 Concavalin A (ConA)
   O Absent (<10% of control)
   O Low (10-30% of control)
   O Normal (>30% of control)
Clinical Features Assessed 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 to report the organism present. Only report an organism once, even if it was identified at the same site in subsequent infections.

For questions 74-82, also report any fungal infections in the Form 2000 - Recipient Baseline Data beginning at question 165.

IF (51) Site of infection: hepatitis := no
THEN GOTO (55) Site of infection: meningitis/encephalitis
ELSE GOTO (52) Organism

Hepatitis Organism

Questions: 52-53

52 Organism:
- Acinetobacter
- Actinomyces
- Bacillus
- Bacteroides (gracillis, uniformis, vulgaris, other species)
- Bordetella pertussis (whooping cough)
- Borrelia (Lyme disease)
<table>
<thead>
<tr>
<th>CIBMTR Center Number:</th>
<th>CIBMTR Recipient ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branhamella or Moraxella catarrhalis (other species)</td>
<td></td>
</tr>
<tr>
<td>Campylobacter (all species)</td>
<td></td>
</tr>
<tr>
<td>Capnocytophaga</td>
<td></td>
</tr>
<tr>
<td>Chlamydia pneumoniae</td>
<td></td>
</tr>
<tr>
<td>Other chlamydia, specify</td>
<td></td>
</tr>
<tr>
<td>Chlamydia, NOS</td>
<td></td>
</tr>
<tr>
<td>Citrobacter (freundii, other species)</td>
<td></td>
</tr>
<tr>
<td>Clostridium (all species except difficile)</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium jeikeium</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium (all non-diptheria species)</td>
<td></td>
</tr>
<tr>
<td>Coxiella</td>
<td></td>
</tr>
<tr>
<td>Enterobacter</td>
<td></td>
</tr>
<tr>
<td>Enterococcus, vancomycin resistant (VRE)</td>
<td></td>
</tr>
<tr>
<td>Enterococcus (all species)</td>
<td></td>
</tr>
<tr>
<td>Escherichia (also E.coli)</td>
<td></td>
</tr>
<tr>
<td>Flavimonas oryzihabitans</td>
<td></td>
</tr>
<tr>
<td>Flavobacterium</td>
<td></td>
</tr>
<tr>
<td>Fusobacterium</td>
<td></td>
</tr>
<tr>
<td>Haemophilus (all species, including influenzae)</td>
<td></td>
</tr>
<tr>
<td>Helicobacter pylori</td>
<td></td>
</tr>
<tr>
<td>Klebsiella</td>
<td></td>
</tr>
<tr>
<td>Lactobacillus (bulgaricus, acidophilus, other species)</td>
<td></td>
</tr>
<tr>
<td>Legionella</td>
<td></td>
</tr>
<tr>
<td>Leptospira</td>
<td></td>
</tr>
<tr>
<td>Leptorichia buccalis</td>
<td></td>
</tr>
<tr>
<td>Leuconostoc (all species)</td>
<td></td>
</tr>
<tr>
<td>Listeria</td>
<td></td>
</tr>
<tr>
<td>Methyllobacterium</td>
<td></td>
</tr>
<tr>
<td>Micrococcus, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium avium-intracellulare (MAC, MAI)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium species (cheloneae, fortuitum, haemophilum, kansasii, mucogenicum)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (tuberculosis, Koch bacillus)</td>
<td></td>
</tr>
<tr>
<td>Other mycobacterium, specify</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma</td>
<td></td>
</tr>
<tr>
<td>Neisseria (gonorrhoea, meningitidis, other species)</td>
<td></td>
</tr>
<tr>
<td>Nocardia</td>
<td></td>
</tr>
<tr>
<td>Pasteurella multocida</td>
<td></td>
</tr>
<tr>
<td>Propionibacterium (acnes, avidum, granulosum, other species)</td>
<td></td>
</tr>
<tr>
<td>Proteus</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas (all species except cepacia &amp; maltophilia)</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas or Burkholderia cepacia</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia</td>
<td></td>
</tr>
<tr>
<td>Rhodococcus</td>
<td></td>
</tr>
<tr>
<td>Rickettsia</td>
<td></td>
</tr>
<tr>
<td>Salmonella (all species)</td>
<td></td>
</tr>
<tr>
<td>Serratia marcescens</td>
<td></td>
</tr>
<tr>
<td>Shigella</td>
<td></td>
</tr>
<tr>
<td>Staphylococcus, coagulase negative (not aureus)</td>
<td></td>
</tr>
<tr>
<td>CIBMTR Center Number:</td>
<td>CIBMTR Recipient ID:</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>

**Today's Date:**
- Month [ ]
- Day [20]
- Year [ ]

**Infusion Date:**
- Month [ ]
- Day [20]
- Year [ ]

**CIBMTR Center Number:**

- **Staphylococcus aureus**
- **Staphylococcus, NOS**
- **Stomatococcus mucilaginosis**
- **Streptococcus (all species except Enterococcus)**
- **Streptococcus pneumoniae**
- **Treponema (syphilis)**
- **Vibrio (all species)**
- **Multiple bacteria at a single site, specify bacterial codes**
- **Other bacteria, specify**
- **Suspected atypical bacterial infection**
- **Suspected bacterial infection**
- **Candida, NOS**
- **Candida albicans**
- **Candida guillermondi**
- **Candida krusei**
- **Candida lusitaniae**
- **Candida parapsilosis**
- **Candida tropicalis**
- **Candida (Torulopsis) glabrata**
- **Other Candida, specify**
- **Aspergillus, NOS**
- **Aspergillus flavus**
- **Aspergillus fumigatus**
- **Aspergillus niger**
- **Other aspergillus, specify**
- **Cryptococcus species**
- **Fusarium species**
- **Histoplasmosis**
- **Zygomycetes, NOS**
- **Mucormycosis**
- **Rhizopus**
- **Yeast, NOS**
- **Other fungus, specify**
- **Pneumocystis (PCP / PJP)**
- **Suspected fungal infection**
- **Herpes simplex (HSV1, HSV2)**
- **Varicella (herpes zoster, chicken pox)**
- **Cytomegalovirus (CMV)**
- **Adenovirus**
- **Enterovirus (coxsackie, echo, polio)**
- **Hepatitis A (HAV)**
- **Hepatitis B (HBV, Australian antigen)**
- **Hepatitis C (HCV)**
- **HIV-1 (HTLV-III)**
- **Influenza, NOS**
- **Influenza A**
- **Influenza B**
- **Measles (Rubeola)**
- **Mumps**
- **Progressive multifocal leukoencephalopathy (PML)**

---

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).
Respiratory syncytial virus (RSV)
Rubella (German Measles)
Parainfluenza
Human herpesvirus-6 (HHV-6)
Epstein-Barr virus (EBV)
Polyoma virus (BK virus, JC virus)
Rotavirus
Rhinovirus
Human papilloma virus (HPV)
Other virus, specify
Suspected viral infection
Toxoplasma
Giardia
Cryptosporidium
Other parasite, specify
Suspected parasite infection
No organism identified

IF (52) Organism:= Other chlamydia, specify OR (52) Organism:= Other mycobacterium, specify
THEN GOTO (53) Specify other organism
ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

IF (52) Organism:= Other virus, specify
THEN GOTO (53) Specify other organism
ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

IF (52) Organism:= Other Candida, specify OR (52) Organism:= Other aspergillus, specify
THEN GOTO (53) Specify other organism
ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

IF (52) Organism:= Other fungus, specify OR (52) Organism:= Other virus, specify
THEN GOTO (53) Specify other organism
ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

IF (52) Organism:= Multiple bacteria at a single site, specify bacterial codes OR (52) Organism:= Other bacteria, specify
THEN GOTO (53) Specify other organism
ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

53 Specify:

ELSE GOTO (54) If hepatitis was present, was it a prominent feature of ID?

Copy questions 52-53 if needed for Hepatitis Organism

54 If hepatitis was present, was it a prominent feature of ID?
  O yes
  O no

ELSE GOTO (55) Site of infection: meningitis/encephalitis

55 Site of infection: meningitis/encephalitis
  O yes
  O no

IF (55) Site of infection: meningitis/encephalitis:= no
THEN GOTO (59) Site of infection: pneumonia
ELSE GOTO (56) Organism
<table>
<thead>
<tr>
<th>Meningitis / Encephalitis Organism</th>
<th>Questions: 56-57</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinetobacter</td>
<td></td>
</tr>
<tr>
<td>Actinomyces</td>
<td></td>
</tr>
<tr>
<td>Bacillus</td>
<td></td>
</tr>
<tr>
<td>Bacteroides (gracillis, uniformis, vulgaris, other species)</td>
<td></td>
</tr>
<tr>
<td>Bordetella pertussis (whooping cough)</td>
<td></td>
</tr>
<tr>
<td>Borrelia (Lyme disease)</td>
<td></td>
</tr>
<tr>
<td>Brachymella or Moraxella catarrhalis (other species)</td>
<td></td>
</tr>
<tr>
<td>Campylobacter (all species)</td>
<td></td>
</tr>
<tr>
<td>Capnocytophaga</td>
<td></td>
</tr>
<tr>
<td>Chlamydia pneumoniae</td>
<td></td>
</tr>
<tr>
<td>Other chlamydia, specify</td>
<td></td>
</tr>
<tr>
<td>Chlamydia, NOS</td>
<td></td>
</tr>
<tr>
<td>Citrobacter (freundii, other species)</td>
<td></td>
</tr>
<tr>
<td>Clostridium (all species except difficile)</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium jeikeium</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium (all non-diptheria species)</td>
<td></td>
</tr>
<tr>
<td>Coxiella</td>
<td></td>
</tr>
<tr>
<td>Enterobacter</td>
<td></td>
</tr>
<tr>
<td>Enterococcus, vancomycin resistant (VRE)</td>
<td></td>
</tr>
<tr>
<td>Enterococcus (all species)</td>
<td></td>
</tr>
<tr>
<td>Escherichia (also E.coli)</td>
<td></td>
</tr>
<tr>
<td>Flavimonas oryzihabitans</td>
<td></td>
</tr>
<tr>
<td>Flavobacterium</td>
<td></td>
</tr>
<tr>
<td>Fusobacterium</td>
<td></td>
</tr>
<tr>
<td>Haemophilus (all species, including influenzae)</td>
<td></td>
</tr>
<tr>
<td>Helicobacter pylori</td>
<td></td>
</tr>
<tr>
<td>Klebsiella</td>
<td></td>
</tr>
<tr>
<td>Lactobacillus (bulgaricus, acidophilus, other species)</td>
<td></td>
</tr>
<tr>
<td>Legionella</td>
<td></td>
</tr>
<tr>
<td>Leptospira</td>
<td></td>
</tr>
<tr>
<td>Leptorichia buccalis</td>
<td></td>
</tr>
<tr>
<td>Leuconostoc (all species)</td>
<td></td>
</tr>
<tr>
<td>Listeria</td>
<td></td>
</tr>
<tr>
<td>Methylcobacterium</td>
<td></td>
</tr>
<tr>
<td>Micrococcus, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium avium-intracellulare (MAC, MAI)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium species (cheloneae, fortuitum, haemophilum, kanssii, mucogenicum)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (tuberculosis, Koch bacillus)</td>
<td></td>
</tr>
<tr>
<td>Other mycobacterium, specify</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma</td>
<td></td>
</tr>
<tr>
<td>Neisseria (gonorrhoea, meningitidis, other species)</td>
<td></td>
</tr>
<tr>
<td>Nocardia</td>
<td></td>
</tr>
<tr>
<td>Pasteurella multocida</td>
<td></td>
</tr>
<tr>
<td>CIBMTR Center Number:</td>
<td>CIBMTR Recipient ID:</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>

- Propionibacterium (acnes, avidum, granulosum, other species)
- Proteus
- Pseudomonas (all species except cepacia & maltophilia)
- Pseudomonas or Burkholderia cepacia
- Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
- Rhodococcus
- Rickettsia
- Salmonella (all species)
- Serratia marcescens
- Shigella
- Staphylococcus, coagulase negative (not aureus)
- Staphylococcus aureus
- Staphylococcus, NOS
- Stomatococcus mucilaginosus
- Streptococcus (all species except Enterococcus)
- Streptococcus pneumoniae
- Treponema (syphilis)
- Vibrio (all species)
- Multiple bacteria at a single site, specify bacterial codes
- Other bacteria, specify
- Suspected atypical bacterial infection
- Suspected bacterial infection
- Candida, NOS
- Candida albicans
- Candida guilliermondii
- Candida krusei
- Candida lusitaniae
- Candida parapsilosis
- Candida tropicalis
- Candida (Torulopsis) glabrata
- Other Candida, specify
- Aspergillus, NOS
- Aspergillus flavus
- Aspergillus fumigatus
- Aspergillus niger
- Other aspergillus, specify
- Cryptococcus species
- Fusarium species
- Histoplasmosis
- Zygomycetes, NOS
- Mucormycosis
- Rhizopus
- Yeast, NOS
- Other fungus, specify
- Pneumocystis (PCP / PJP)
- Suspected fungal infection
- Herpes simplex (HSV1, HSV2)
- Varicella (herpes zoster, chicken pox)
- Cytomegalovirus (CMV)
- Adenovirus

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).
CIBMTR Center Number: ____________________________
CIBMTR Recipient ID: ____________________________

- Enterovirus (coxsackie, echo, polio)
- Hepatitis A (HAV)
- Hepatitis B (HBV, Australian antigen)
- Hepatitis C (HCV)
- HIV-1 (HTLV-III)
- Influenza, NOS
- Influenza A
- Influenza B
- Measles (Rubeola)
- Mumps
- Progressive multifocal leukoencephalopathy (PML)
- Respiratory syncytial virus (RSV)
- Rubella (German Measles)
- Parainfluenza
- Human herpesvirus-6 (HHV-6)
- Epstein-Barr virus (EBV)
- Polyoma virus (BK virus, JC virus)
- Rotavirus
- Rhinovirus
- Human papilloma virus (HPV)
- Other virus, specify
- Suspected viral infection
- Toxoplasma
- Giardia
- Cryptosporidium
- Other parasite, specify
- Suspected parasite infection
- No organism identified

IF (56) Organism:= Other chlamydia, specify OR (56) Organism:= Other mycobacterium, specify
THEN GOTO (57) Specify other organism
ELSE GOTO (58) If meningitis / encephalitis was present, was it a prominent feature of ID?
IF (56) Organism:= Other Candida, specify OR (56) Organism:= Other fungus, specify
THEN GOTO (57) Specify other organism
ELSE GOTO (58) If meningitis / encephalitis was present, was it a prominent feature of ID?
IF (56) Organism:= Other parasite, specify
ELSE GOTO (58) If meningitis / encephalitis was present, was it a prominent feature of ID?

Specify: ____________________________

ELSE GOTO (58) If meningitis / encephalitis was present, was it a prominent feature of ID?
Copy questions 56-57 if needed for Meningitis / Encephalitis Organism

58 If meningitis / encephalitis was present, was it a prominent feature of ID?
   O yes
   O no
   ELSE GOTO (59) Site of infection: pneumonia

59 Site of infection: pneumonia
   O yes
   O no
   IF (59) Site of infection: pneumonia:= no
   THEN GOTO (63) Site of infection: severe or protracted diarrhea
   ELSE GOTO (60) Organism

Pneumonia Organism

Questions: 60-61

60 Organism:
   O Acinetobacter
   O Actinomyces
   O Bacillus
   O Bacteroides(gracillis,uniformis,vulgaris, other species)
   O Bordetella pertussis (whooping cough)
   O Borrelia (Lyme disease)
   O Branhamella or Moraxella catarrhalis(other species)
   O Campylobacter (all species)
   O Capnocytophaga
   O Chlamydia pneumoniae
   O Other chlamydia, specify
   O Chlamydia, NOS
   O Citrobacter (freundii, other species)
   O Clostridium (all species except difficile)
   O Clostridium difficile
   O Corynebacterium jeikeium
   O Corynebacterium (all non-diptheria species)
   O Coxiella
   O Enterobacter
   O Enterococcus, vancomycin resistant(VRE)
   O Enterococcus(all species)
   O Escherichia (also E.coli)
   O Flavimonas oryzihabitans
   O Flavobacterium
   O Fusobacterium
   O Haemophilus(all species, including influenzae)
   O Helicobacter pylori
   O Klebsiella
   O Lactobacillus(bulgarcicus, acidophilus, other species)
   O Legionella
   O Leptospira
CIBMTR Center Number: ____________________ CIBMTR Recipient ID: ____________________

Leptorichia buccalis
Leuconostoc (all species)
Listeria
Methylobacterium
Micrococcus, NOS
Mycobacterium avium-intracellulare (MAC, MAI)
Mycobacterium species (chelonae, fortuitum, haemophilum, kansasii, mucogenicum)
Mycobacterium tuberculosis (tuberculosis, Koch bacillus)
Other mycobacterium, specify
Mycobacterium, NOS
Mycoplasma
Neisseria (gonorrhoea, meningitidis, other species)
Nocardia
Pasteurella multocida
Propionibacterium (acnes, avidum, granulosum, other species)
Proteus
Pseudomonas (all species except cepacia & maltophilia)
Pseudomonas or Burkholderia cepacia
Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
Rhodococcus
Rickettsia
Salmonella (all species)
Serratia marcescens
Shigella
Staphylococcus, coagulase negative (not aureus)
Staphylococcus aureus
Staphylococcus, NOS
Stomatococcus mucilaginosus
Streptococcus (all species except Enterococcus)
Streptococcus pneumoniae
Treponema (syphilis)
Vibrio (all species)
Multiple bacteria at a single site, specify bacterial codes
Other bacteria, specify
Suspected atypical bacterial infection
Suspected bacterial infection
Candida, NOS
Candida albicans
Candida guillermondi
Candida krusei
Candida lusitaniae
Candida parapsilosis
Candida tropicalis
Candida (Torulopsis) glabrata
Other Candida, specify
Aspergillus, NOS
Aspergillus flavus
Aspergillus fumigatus
Aspergillus niger
Other aspergillus, specify

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).
CIBMTR Center Number: ____________________  CIBMTR Recipient ID: ____________________

O Cryptococcus species
O Fusarium species
O Histoplasmosis
O Zygomycetes, NOS
O Mucormycosis
O Rhizopus
O Yeast, NOS
O Other fungus, specify
O Pneumocystis (PCP / PJP)
O Suspected fungal infection
O Herpes simplex (HSV1, HSV2)
O Varicella (herpes zoster, chicken pox)
O Cytomegalovirus (CMV)
O Adenovirus
O Enterovirus (coxsackie, echo, polio)
O Hepatitis A (HAV)
O Hepatitis B (HBV, Australian antigen)
O Hepatitis C (HCV)
O HIV-1 (HTLV-III)
O Influenza, NOS
O Influenza A
O Influenza B
O Measles (Rubeola)
O Mumps
O Progressive multifocal leukoencephalopathy (PML)
O Respiratory syncytial virus (RSV)
O Rubella (German Measles)
O Parainfluenza
O Human herpesvirus-6 (HHV-6)
O Epstein-Barr virus (EBV)
O Polyoma virus (BK virus, JC virus)
O Rotavirus
O Rhinovirus
O Human papilloma virus (HPV)
O Other virus, specify
O Suspected viral infection
O Toxoplasma
O Giardia
O Cryptosporidium
O Other parasite, specify
O Suspected parasite infection
O No organism identified

IF (60) Organism:= Other chlamydia, specify OR (60) Organism:= Other mycobacterium, specify
THEN GOTO (61) Specify other organism
ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

IF (60) Organism:= Multiple bacteria at a single site, specify bacterial codes OR (60) Organism:= Other bacteria, specify
THEN GOTO (61) Specify other organism
ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

IF (60) Organism:= Other Candida, specify OR (60) Organism:= Other aspergillus, specify
CIBMTR Center Number: __________________________ CIBMTR Recipient ID: __________________________

THEN GOTO (61) Specify other organism
ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

IF (60) Organism:= Other fungus, specify OR (60) Organism:= Other virus, specify
THEN GOTO (61) Specify other organism
ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

IF (60) Organism:= Other parasite, specify
THEN GOTO (61) Specify other organism
ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

61 Specify:
________________________

ELSE GOTO (62) If pneumonia was present. was it a prominent feature of ID?

Copy questions 60-61 if needed for Pneumonia Organism

62 If pneumonia was present. was it a prominent feature of ID?
O yes
O no

ELSE GOTO (63) Site of infection: severe or protracted diarrhea

63 Site of infection: severe or protracted diarrhea
O yes
O no

IF (63) Site of infection: severe or protracted diarrhea:= no
THEN GOTO (67) Site of infection: systemic infection
ELSE GOTO (64) Organism

<table>
<thead>
<tr>
<th>Diarrhea Organism</th>
<th>Questions: 64-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinetobacter</td>
<td></td>
</tr>
<tr>
<td>Actinomyces</td>
<td></td>
</tr>
<tr>
<td>Bacillus</td>
<td></td>
</tr>
<tr>
<td>Bacteroides</td>
<td></td>
</tr>
<tr>
<td>Bordetella pertussis</td>
<td></td>
</tr>
<tr>
<td>Borrelia</td>
<td></td>
</tr>
<tr>
<td>Brachysbacteria</td>
<td></td>
</tr>
<tr>
<td>Campylobacter</td>
<td></td>
</tr>
<tr>
<td>Capnocytophaga</td>
<td></td>
</tr>
<tr>
<td>Chlamydia pneumonia</td>
<td></td>
</tr>
<tr>
<td>Chlamydia, NOS</td>
<td></td>
</tr>
<tr>
<td>Citrobacter</td>
<td></td>
</tr>
<tr>
<td>Clostridium</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium jeikeium</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium (all non-diptheria species)</td>
<td></td>
</tr>
<tr>
<td>Coxiella</td>
<td></td>
</tr>
<tr>
<td>Enterobacter</td>
<td></td>
</tr>
<tr>
<td>Enterococcus, vancomycin resistant(VRE)</td>
<td></td>
</tr>
</tbody>
</table>

CIBMTR Form 2031 revision 3 (page 22 of 50) Last Updated November 29, 2012. 
Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

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).
<table>
<thead>
<tr>
<th>Bacterial Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterococcus (all species)</td>
<td></td>
</tr>
<tr>
<td>Escherichia (also E.coli)</td>
<td></td>
</tr>
<tr>
<td>Flavimonas oryzihabitans</td>
<td></td>
</tr>
<tr>
<td>Flavobacterium</td>
<td></td>
</tr>
<tr>
<td>Fusobacterium</td>
<td></td>
</tr>
<tr>
<td>Haemophilus (all species, including influenzae)</td>
<td></td>
</tr>
<tr>
<td>Helicobacter pylori</td>
<td></td>
</tr>
<tr>
<td>Klebsiella</td>
<td></td>
</tr>
<tr>
<td>Lactobacillus (bulgaricus, acidophilus, other species)</td>
<td></td>
</tr>
<tr>
<td>Legionella</td>
<td></td>
</tr>
<tr>
<td>Leptospira</td>
<td></td>
</tr>
<tr>
<td>Leptorichia buccalis</td>
<td></td>
</tr>
<tr>
<td>Leuconostoc (all species)</td>
<td></td>
</tr>
<tr>
<td>Listeria</td>
<td></td>
</tr>
<tr>
<td>Methyllobacterium</td>
<td></td>
</tr>
<tr>
<td>Micrococcus, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium avium-intracellulare (MAC, MAI)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium species (chelonae, fortuitum, haemophilum, kansasii, mucogenicum)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (tuberculosis, Koch bacillus)</td>
<td></td>
</tr>
<tr>
<td>Other mycobacterium, specify</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma</td>
<td></td>
</tr>
<tr>
<td>Neisseria (gonorrhoea, meningitidis, other species)</td>
<td></td>
</tr>
<tr>
<td>Nocardia</td>
<td></td>
</tr>
<tr>
<td>Pasteurella multocida</td>
<td></td>
</tr>
<tr>
<td>Propionibacterium (acnes, avidum, granulosum, other species)</td>
<td></td>
</tr>
<tr>
<td>Proteus</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas (all species except cepacia &amp; maltophilia)</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas or Burkholderia cepacia</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia</td>
<td></td>
</tr>
<tr>
<td>Rhodococcus</td>
<td></td>
</tr>
<tr>
<td>Rickettsia</td>
<td></td>
</tr>
<tr>
<td>Salmonella (all species)</td>
<td></td>
</tr>
<tr>
<td>Serratia marcescens</td>
<td></td>
</tr>
<tr>
<td>Shigella</td>
<td></td>
</tr>
<tr>
<td>Staphylococcus, coagulase negative (not aureus)</td>
<td></td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td></td>
</tr>
<tr>
<td>Staphylococcus, NOS</td>
<td></td>
</tr>
<tr>
<td>Stomatococcus mucilaginosis</td>
<td></td>
</tr>
<tr>
<td>Streptococcus (all species except Enterococcus)</td>
<td></td>
</tr>
<tr>
<td>Streptococcus pneumoniae</td>
<td></td>
</tr>
<tr>
<td>Treponema (syphilis)</td>
<td></td>
</tr>
<tr>
<td>Vibrio (all species)</td>
<td></td>
</tr>
<tr>
<td>Multiple bacteria at a single site, specify bacterial codes</td>
<td></td>
</tr>
<tr>
<td>Other bacteria, specify</td>
<td></td>
</tr>
<tr>
<td>Suspected atypical bacterial infection</td>
<td></td>
</tr>
<tr>
<td>Suspected bacterial infection</td>
<td></td>
</tr>
<tr>
<td>Candida, NOS</td>
<td></td>
</tr>
<tr>
<td>Candida albicans</td>
<td></td>
</tr>
<tr>
<td>Candida guillermondi</td>
<td></td>
</tr>
</tbody>
</table>

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).
CIBMTR Form 2031 revision 3 (page 24 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

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).
<table>
<thead>
<tr>
<th>Systemic Infection Organism</th>
<th>Questions: 68-69</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinetobacter</td>
<td></td>
</tr>
<tr>
<td>Actinomyces</td>
<td></td>
</tr>
<tr>
<td>Bacillus</td>
<td></td>
</tr>
<tr>
<td>Bacteroides (gracillis, uniformis, vulgaris, other species)</td>
<td></td>
</tr>
<tr>
<td>Bordetella pertussis (whooping cough)</td>
<td></td>
</tr>
<tr>
<td>Borrelia (Lyme disease)</td>
<td></td>
</tr>
<tr>
<td>Branhambella or Moraxella catarrhalis (other species)</td>
<td></td>
</tr>
<tr>
<td>Campylobacter (all species)</td>
<td></td>
</tr>
<tr>
<td>Capnocytophaga</td>
<td></td>
</tr>
</tbody>
</table>

Copy questions 64-65 if needed for Diarrhea Organism

65 Specify:

ELSE GOTO (66) If diarrhea was present, was it a prominent feature of ID?

If diarrhea was present, was it a prominent feature of ID?

O yes
O no

ELSE GOTO (67) Site of infection: systemic infection

Site of infection: systemic infection

O yes
O no

IF (67) Site of infection: systemic infection := no

THEN GOTO (71) Site of infection: other infection

ELSE GOTO (68) Organism
<table>
<thead>
<tr>
<th>CIBMTR Center Number:</th>
<th>CIBMTR Recipient ID:</th>
</tr>
</thead>
</table>

**CIBMTR Form 2031 revision 3 (page 26 of 50) Last Updated November 29, 2012.**

Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

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).
| **Streptococcus (all species except Enterococcus)** | **Streptococcus pneumoniae** |
| **Treponema (syphilis)** | **Vibrio (all species)** |
| **Multiple bacteria at a single site, specify bacterial codes** | **Other bacteria, specify** |
| **Suspected atypical bacterial infection** | **Suspected bacterial infection** |
| **Candida, NOS** | **Candida albicans** |
| **Candida guillermondii** | **Candida krusei** |
| **Candida lusitaniae** | **Candida parapsilosis** |
| **Candida tropicalis** | **Candida (Torulopsis) glabrata** |
| **Other Candida, specify** | **Aspergillus, NOS** |
| **Aspergillus flavus** | **Aspergillus fumigatus** |
| **Aspergillus niger** | **Other aspergillus, specify** |
| **Cryptococcus species** | **Fusarium species** |
| **Histoplasmosis** | **Zygomycetes, NOS** |
| **Yeast, NOS** | **Other fungus, specify** |
| **Pneumocystis (PCP / PJP)** | **Suspected fungal infection** |
| **Herpes simplex (HSV1, HSV2)** | **Varicella (herpes zoster, chicken pox)** |
| **Cytomegalovirus (CMV)** | **Adenovirus** |
| **Enterovirus (coxsackie, echo, polio)** | **Hepatitis A (HAV)** |
| **Hepatitis B (HBV, Australian antigen)** | **Hepatitis C (HCV)** |
| **HIV-1 (HTLV-III)** | **Influenza, NOS** |
| **Influenza A** | **Influenza B** |
| **Measles (Rubeola)** | **Mumps** |
| **Progressive multifocal leukoencephalopathy (PML)** | **Respiratory syncytial virus (RSV)** |
| **Rubella (German Measles)** | **Parainfluenza** |
CIBMTR Form 2031 revision 3 (page 28 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.

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).
<table>
<thead>
<tr>
<th>Other Infection Organism</th>
<th>Questions: 72-74</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acinetobacter</td>
<td></td>
</tr>
<tr>
<td>Actinomyces</td>
<td></td>
</tr>
<tr>
<td>Bacillus</td>
<td></td>
</tr>
<tr>
<td>Bacteroides (gracilis, uniformis, vulgaris, other species)</td>
<td></td>
</tr>
<tr>
<td>Bordetella pertussis (whooping cough)</td>
<td></td>
</tr>
<tr>
<td>Borrelia (Lyme disease)</td>
<td></td>
</tr>
<tr>
<td>Branhamella or Moraxella catarrhalis (other species)</td>
<td></td>
</tr>
<tr>
<td>Campylobacter (all species)</td>
<td></td>
</tr>
<tr>
<td>Capnocytophaga</td>
<td></td>
</tr>
<tr>
<td>Chlamydia pneumoniae</td>
<td></td>
</tr>
<tr>
<td>Other chlamydia, specify</td>
<td></td>
</tr>
<tr>
<td>Chlamydia, NOS</td>
<td></td>
</tr>
<tr>
<td>Citrobacter (freundii, other species)</td>
<td></td>
</tr>
<tr>
<td>Clostridium (all species except difficile)</td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium jeikeium</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium (all non-diptheria species)</td>
<td></td>
</tr>
<tr>
<td>Coxiella</td>
<td></td>
</tr>
<tr>
<td>Enterobacter</td>
<td></td>
</tr>
<tr>
<td>Enterococcus, vancomycin resistant (VRE)</td>
<td></td>
</tr>
<tr>
<td>Enterococcus (all species)</td>
<td></td>
</tr>
<tr>
<td>Escherichia (also E.coli)</td>
<td></td>
</tr>
<tr>
<td>Flavimonas oryzihabitans</td>
<td></td>
</tr>
<tr>
<td>Flavobacterium</td>
<td></td>
</tr>
<tr>
<td>Fusobacterium</td>
<td></td>
</tr>
<tr>
<td>Haemophilus (all species, including influenzae)</td>
<td></td>
</tr>
<tr>
<td>Helicobacter pylori</td>
<td></td>
</tr>
<tr>
<td>Klebsiella</td>
<td></td>
</tr>
<tr>
<td>Lactobacillus (bulgaricus, acidophilus, other species)</td>
<td></td>
</tr>
<tr>
<td>Legionella</td>
<td></td>
</tr>
<tr>
<td>Leptospiira</td>
<td></td>
</tr>
<tr>
<td>Leptorichia buccalis</td>
<td></td>
</tr>
<tr>
<td>Leuconostoc (all species)</td>
<td></td>
</tr>
<tr>
<td>Listeria</td>
<td></td>
</tr>
<tr>
<td>Methylobacterium</td>
<td></td>
</tr>
<tr>
<td>Micrococcus, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium avium-intracellulare (MAC, MAI)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium species (cheloneae, fortuitum, haemophilum, kansasii, mucogenicum)</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (tuberculosis, Koch bacillus)</td>
<td></td>
</tr>
<tr>
<td>Other mycobacterium, specify</td>
<td></td>
</tr>
<tr>
<td>Mycobacterium, NOS</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma</td>
<td></td>
</tr>
<tr>
<td>Neisseria (gonorrhoea, meningitidis, other species)</td>
<td></td>
</tr>
<tr>
<td>Nocardia</td>
<td></td>
</tr>
<tr>
<td>Pasteurella multocida</td>
<td></td>
</tr>
<tr>
<td>Propionibacterium (acnes, avidum, granulosum, other species)</td>
<td></td>
</tr>
<tr>
<td>CIBMTR Center Number:</td>
<td>CIBMTR Recipient ID:</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>○ Proteus</td>
<td>○ Pseudomonas (all species except cepacia &amp; maltophilia)</td>
</tr>
<tr>
<td>○ Pseudomonas or Burkholderia cepacia</td>
<td>○ Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia</td>
</tr>
<tr>
<td>○ Rhodococcus</td>
<td>○ Rickettsia</td>
</tr>
<tr>
<td>○ Salmonella (all species)</td>
<td>○ Serratia marcescens</td>
</tr>
<tr>
<td>○ Shigella</td>
<td>○ Staphylococcus, coagulase negative (not aureus)</td>
</tr>
<tr>
<td>○ Staphylococcus aureus</td>
<td>○ Staphylococcus, NOS</td>
</tr>
<tr>
<td>○ Stomatococcus mucilaginosus</td>
<td>○ Streptococcus (all species except Enterococcus)</td>
</tr>
<tr>
<td>○ Streptococcus pneumonia</td>
<td>○ Treponema (syphilis)</td>
</tr>
<tr>
<td>○ Vibrio (all species)</td>
<td>○ Multiple bacteria at a single site, specify bacterial codes</td>
</tr>
<tr>
<td>○ Other bacteria, specify</td>
<td>○ Other bacteria, specify</td>
</tr>
<tr>
<td>○ Suspected atypical bacterial infection</td>
<td>○ Suspected bacterial infection</td>
</tr>
<tr>
<td>○ Candida, NOS</td>
<td>○ Candida albicans</td>
</tr>
<tr>
<td>○ Candida guillermondi</td>
<td>○ Candida krusei</td>
</tr>
<tr>
<td>○ Candida lusitaniae</td>
<td>○ Candida parapsilosis</td>
</tr>
<tr>
<td>○ Candida tropicalis</td>
<td>○ Candida (Torulopsis) glabrata</td>
</tr>
<tr>
<td>○ Other Candida, specify</td>
<td>○ Aspergillus, NOS</td>
</tr>
<tr>
<td>○ Aspergillus flavus</td>
<td>○ Aspergillus fumigatus</td>
</tr>
<tr>
<td>○ Aspergillus niger</td>
<td>○ Other aspergillus, specify</td>
</tr>
<tr>
<td>○ Cryptococcus species</td>
<td>○ Fusarium species</td>
</tr>
<tr>
<td>○ Histoplasmosis</td>
<td>○ Zygomycetes, NOS</td>
</tr>
<tr>
<td>○ Mucormycosis</td>
<td>○ Rhizopus</td>
</tr>
<tr>
<td>○ Yeast, NOS</td>
<td>○ Other fungus, specify</td>
</tr>
<tr>
<td>○ Pneumocystis (PCP / PJP)</td>
<td>○ Suspected fungal infection</td>
</tr>
<tr>
<td>○ Herpes simplex (HSV1, HSV2)</td>
<td>○ Varicella (herpes zoster, chicken pox)</td>
</tr>
<tr>
<td>○ Cytomegalovirus (CMV)</td>
<td>○ Adenovirus</td>
</tr>
</tbody>
</table>
| ○ Enterovirus (coxsackie, echo, polio) | }
CIBMTR Center Number: ____________
CIBMTR Recipient ID: __________________________

**Error Correction Form**

<table>
<thead>
<tr>
<th>Sequence Number:</th>
<th>CIBMTR Recipient ID:</th>
<th>Initials:</th>
</tr>
</thead>
</table>

**Today's Date:**
- Month: ___________
- Day: 20
- Year: ___________

**Infusion Date:**
- Month: ___________
- Day: 20
- Year: ___________

**CIBMTR Center Number:** ___________

### Available Infections

- Hepatitis A (HAV)
- Hepatitis B (HBV, Australian antigen)
- Hepatitis C (HCV)
- HIV-1 (HTLV-III)
- Influenza, NOS
- Influenza A
- Influenza B
- Measles (Rubeola)
- Mumps
- Progressive multifocal leukoencephalopathy (PML)
- Respiratory syncytial virus (RSV)
- Rubella (German Measles)
- Parainfluenza
- Human herpesvirus-6 (HHV-6)
- Epstein-Barr virus (EBV)
- Polyoma virus (BK virus, JC virus)
- Rotavirus
- Rhinovirus
- Human papilloma virus (HPV)
- Other virus, specify
- Suspected viral infection
- Toxoplasma
- Giardia
- Cryptosporidium
- Other parasite, specify
- Suspected parasite infection
- No organism identified

**IF (72) Organism:= Multiple bacteria at a single site, specify bacterial codes OR (72) Organism:= Other bacteria, specify**

**THEN GOTO (73) Specify other organism**

**ELSE GOTO (74) Specify other infection site:**

**IF (72) Organism:= Other chlamydia, specify OR (72) Organism:= Other mycobacterium, specify**

**THEN GOTO (73) Specify other organism**

**ELSE GOTO (74) Specify other infection site:**

**IF (72) Organism:= Other Candida, specify OR (72) Organism:= Other aspergillus, specify**

**THEN GOTO (73) Specify other organism**

**ELSE GOTO (74) Specify other infection site:**

**IF (72) Organism:= Other fungus, specify OR (72) Organism:= Other virus, specify**

**THEN GOTO (73) Specify other organism**

**ELSE GOTO (74) Specify other infection site:**

**IF (72) Organism:= Other parasite, specify**

**THEN GOTO (73) Specify other organism**

**ELSE GOTO (74) Specify other infection site:**

73 Specify:

- ELSE GOTO (74) Specify other infection site:

74 Specify other infection site: __________________________

**ELSE GOTO (75) If other infection was present, was it a prominent feature of ID?**
Copy questions 72-74 if needed for Other Infection Organism

75 If other infection was present, was it a prominent feature of ID?

   O yes
   O no

ELSE GOTO (76) Did the recipient experience any of the following clinical features (between diagnosis and prior to the preparative regimen)?

Clinical Status between Diagnosis and the Preparative Regimen

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

   O yes
   O no

IF (76) Did the recipient experience any of the following clinical features (between diagnosis and prior to the preparative regimen)?

   O no

THEN GOTO (116) Was treatment given (between diagnosis and prior to the preparative regimen)?

ELSE GOTO (77) Is autoimmune hemolytic anemia present?

Specify clinical features:

77 Is autoimmune hemolytic anemia present?

   O yes
   O no

IF (77) Is autoimmune hemolytic anemia present?

   O no

THEN GOTO (79) Are bone abnormalities present?

ELSE GOTO (78) If present, is the feature prominent?

78 Is autoimmune hemolytic anemia prominent?

   O yes
   O no

ELSE GOTO (79) Are bone abnormalities present?

79 Are bone abnormalities present?

   O yes
   O no

IF (79) Are bone abnormalities present?

   O no

THEN GOTO (81) Is edema present?

ELSE GOTO (80) If present, is the feature prominent?

80 Are bone abnormalities prominent?

   O yes
   O no

ELSE GOTO (81) Is edema present?

81 Is edema present?

   O yes
   O no

IF (81) Is edema present?

   O no

THEN GOTO (83) Is eosinophilia present?

ELSE GOTO (82) If present, is the feature prominent?
82 Is edema prominent?
   O yes
   O no
   ELSE GOTO (83) Is eosinophilia present?

83 Is eosinophilia present?
   O yes
   O no
   IF (83) Is eosinophilia present?:= no
   THEN GOTO (85) Is failure to thrive (weight<5th percentile) present?
   ELSE GOTO (84) If present, is the feature prominent?

84 Is eosinophilia prominent?
   O yes
   O no
   ELSE GOTO (85) Is failure to thrive (weight<5th percentile) present?

85 Is failure to thrive (weight<5th percentile) present?
   O yes
   O no
   IF (85) Is failure to thrive (weight<5th percentile) present?:= no
   THEN GOTO (87) Is graft versus host disease due to blood transfusion present?
   ELSE GOTO (86) If present, is the feature prominent?

86 Is failure to thrive (weight < 5th percentile) prominent?
   O yes
   O no
   ELSE GOTO (87) Is graft versus host disease due to blood transfusion present?

87 Is graft versus host disease due to blood transfusion present?
   O yes
   O no
   IF (87) Is graft versus host disease due to blood transfusion present?:= no
   THEN GOTO (89) Is graft versus host disease due to maternal engraftment present?
   ELSE GOTO (88) If present, is the feature prominent?

88 Is graft versus host disease due to blood transfusion prominent?
   O yes
   O no
   ELSE GOTO (89) Is graft versus host disease due to maternal engraftment present?

89 Is graft versus host disease due to maternal engraftment present?
   O yes
   O no
   IF (89) Is graft versus host disease due to maternal engraftment present?:= no
   THEN GOTO (91) Is growth hormone deficiency present?
ELSE GOTO (90) If present, is the feature prominent?

90 Is graft versus host disease due to maternal engraftment prominent?
   O yes
   O no

ELSE GOTO (91) Is growth hormone deficiency present?

91 Is growth hormone deficiency present?
   O yes
   O no

IF (91) Is growth hormone deficiency present?:= no
THEN GOTO (93) Is growth retardation (height<5th percentile) present?
ELSE GOTO (92) If present, is the feature prominent?

92 Is growth hormone deficiency prominent?
   O yes
   O no

ELSE GOTO (93) Is growth retardation (height<5th percentile) present?

93 Is growth retardation (height<5th percentile) present?
   O yes
   O no

IF (93) Is growth retardation (height<5th percentile) present?:= no
THEN GOTO (95) Is hepatosplenomegaly present?
ELSE GOTO (94) If present, is the feature prominent?

94 Is growth retardation (height < 5th percentile) prominent?
   O yes
   O no

ELSE GOTO (95) Is hepatosplenomegaly present?

95 Is hepatosplenomegaly present?
   O yes
   O no

IF (95) Is hepatosplenomegaly present?:= no
THEN GOTO (97) Is hypoproteinemia present?
ELSE GOTO (96) If present, is the feature prominent?

96 Is hepatosplenomegaly prominent?
   O yes
   O no

ELSE GOTO (97) Is hypoproteinemia present?

97 Is hypoproteinemia present?
   O yes
   O no

IF (97) Is hypoproteinemia present?:= no
THEN GOTO (99) Is lymphoproliferative disease present?
ELSE GOTO (98) If present, is the feature prominent?
CIBMTR Center Number: ___________________________ CIBMTR Recipient ID: ___________________________

98 Is hypoproteinemia prominent?
  O yes
  O no
  ELSE GOTO (99) Is lymphoproliferative disease present?

99 Is lymphoproliferative disease present?
  O yes
  O no
  IF (99) Is lymphoproliferative disease present? := no
  THEN GOTO (101) Is maternal T-cell engraftment present?
  ELSE GOTO (100) If present, is the feature prominent?

100 Is lymphoproliferative disease prominent?
  O yes
  O no
  ELSE GOTO (101) Is maternal T-cell engraftment present?

101 Is maternal T-cell engraftment present?
  O yes
  O no
  IF (101) Is maternal T-cell engraftment present? := no
  THEN GOTO (103) Is microcephaly present?
  ELSE GOTO (102) If present, is the feature prominent?

102 Is maternal T-cell engraftment prominent?
  O yes
  O no
  ELSE GOTO (103) Is microcephaly present?

103 Is microcephaly present?
  O yes
  O no
  IF (103) Is microcephaly present? := no
  THEN GOTO (105) Is neutropenia present?
  ELSE GOTO (104) If present, is the feature prominent?

104 Is microcephaly prominent?
  O yes
  O no
  ELSE GOTO (105) Is neutropenia present?

105 Is neutropenia present?
  O yes
  O no
  IF (105) Is neutropenia present? := no
  THEN GOTO (107) Is skin rash present?
  ELSE GOTO (106) If present, is the feature prominent?
106 Is neutropenia prominent?
   O yes
   O no
   ELSE GOTO (107) Is skin rash present?

107 Is skin rash present?
   O yes
   O no
   IF (107) Is skin rash present?:= no
   THEN GOTO (109) Is thrombocytopenia (< 100 x 10^9/L) present?
   ELSE GOTO (108) If present, is the feature prominent?

108 Is skin rash prominent?
   O yes
   O no
   ELSE GOTO (109) Is thrombocytopenia (< 100 x 10^9/L) present?

109 Is thrombocytopenia (< 100 x 10^9/L) present?
   O yes
   O no
   IF (109) Is thrombocytopenia (< 100 x 10^9/L) present?:= no
   THEN GOTO (111) Are warts present?
   ELSE GOTO (110) If present, is the feature prominent?

110 Is thrombocytopenia (< 100 x 10^9/L) prominent?
   O yes
   O no
   ELSE GOTO (111) Are warts present?

111 Are warts present?
   O yes
   O no
   IF (111) Are warts present?:= no
   THEN GOTO (113) Are other clinical features present?
   ELSE GOTO (112) If present, is the feature prominent?

112 Are warts prominent?
   O yes
   O no
   ELSE GOTO (113) Are other clinical features present?

113 Are other clinical features present?
   O yes
   O no
IF (113) Are other clinical features present?: = no
THEN GOTO (116) Was treatment given (between diagnosis and prior to the preparative regimen)?
ELSE GOTO (114) If present, is the feature prominent?

114 Are other clinical features prominent?
   O yes
   O no

ELSE GOTO (115) Specify other clinical features:

115 Specify other clinical features:
   ____________________________

ELSE GOTO (116) Was treatment given (between diagnosis and prior to the preparative regimen)?

Pre-HSCT Treatment for Immune Deficiency

116 Was treatment given (between diagnosis and prior to the preparative regimen)?
   O yes
   O no

IF (116) Was treatment given (between diagnosis and prior to the preparative regimen)? = no
THEN GOTO (176) Did the recipient receive parenteral nutrition (between diagnosis and prior to the preparative regimen)?
ELSE GOTO (117) Were antifungal drug(s) given as prophylaxis?

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

117 Were antifungal drug(s) given as prophylaxis?
   O yes
   O no

IF (117) Were antifungal drug(s) given as prophylaxis? = no
THEN GOTO (120) Were antiviral drug(s) given as prophylaxis?
ELSE GOTO (118) Antifungal drug stopped?

118 Were prophylactic antifungal drug(s) stopped?
   O yes
   O no

IF (118) Antifungal drug stopped? = no
THEN GOTO (120) Were antiviral drug(s) given as prophylaxis?
ELSE GOTO (119) Date prophylactic antifungal drug(s) stopped unknown

119 Date prophylactic antifungal drug(s) stopped unknown
   IF (119) Date prophylactic antifungal drug(s) stopped unknown = checked
   THEN GOTO (120) Were antiviral drug(s) given as prophylaxis?
   ELSE GOTO date estimated

   □ date estimated
   ELSE GOTO Date stopped

Date prophylactic antifungal drug(s) stopped: _____________ MMM DD

ELSE GOTO (120) Were antiviral drug(s) given as prophylaxis?
120 Were antiviral drug(s) given as prophylaxis?
   O yes
   O no
   IF (120) Were antiviral drug(s) given as prophylaxis?: = no
   THEN GOTO (123) Was co-trimoxazole (Bactim, Septra) given as prophylaxis?
   ELSE GOTO (121) Antiviral drug stopped?

121 Were prophylactic antiviral drug(s) stopped?
   O yes
   O no
   IF (121) Antiviral drug stopped?: = no
   THEN GOTO (123) Was co-trimoxazole (Bactim, Septra) given as prophylaxis?
   ELSE GOTO (122) Date prophylactic antiviral drug(s) stopped unknown

122 □ Date prophylactic antiviral drug(s) stopped unknown
   IF (122) Date prophylactic antiviral drug(s) stopped unknown:= checked
   THEN GOTO (123) Was co-trimoxazole (Bactim, Septra) given as prophylaxis?
   ELSE GOTO date estimated

123 Was co-trimoxazole (Bactim, Septra) given as prophylaxis?
   O yes
   O no
   IF (123) Was co-trimoxazole (Bactim, Septra) given as prophylaxis?: = no
   THEN GOTO (126) Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?
   ELSE GOTO (124) Co-trimoxazole stopped?

124 Was co-trimoxazole (Bactrim, Septra) stopped?
   O yes
   O no
   IF (124) Co-trimoxazole stopped?: = no
   THEN GOTO (126) Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?
   ELSE GOTO (125) Date co-trimoxazole (Bactrim, Septr) stopped unknown

125 □ Date co-trimoxazole (Bactrim, Septr) stopped unknown
   IF (125) Date co-trimoxazole (Bactrim, Septr) stopped unknown:= checked
   THEN GOTO (126) Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?
   ELSE GOTO date estimated
date estimated
ELSE GOTO Date stopped

Date co-trimoxazole (Bactrim, Septra) stopped: _______ yyyy _______ mm _______ dd

ELSE GOTO (126) Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?

Therapy paused for < 1 week should not be considered as “Therapy Stopped.”

126 Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?
  O yes
  O no

IF (126) Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) given as therapy?:= no
THEN GOTO (129) Were systemic corticosteroids given as therapy?
ELSE GOTO (127) Antithymocyte globulin stopped?

127 Was antithymocyte globulin (ATG, ATGAM, Thymoglobulin) stopped?
  O yes
  O no

IF (127) Antithymocyte globulin stopped?:= no
THEN GOTO (129) Were systemic corticosteroids given as therapy?
ELSE GOTO (128) Date antithymocyte globulin (ATG, ATGAM, Thymoglobulin) stopped unknown

128 Date antithymocyte globulin (ATG, ATGAM, Thymoglobulin) stopped unknown
IF (128) Date antithymocyte globulin (ATG, ATGAM, Thymoglobulin) stopped unknown:= checked
THEN GOTO (129) Were systemic corticosteroids given as therapy?
ELSE GOTO date estimated

date estimated
ELSE GOTO Date Stopped

Date antithymocyte globulin (ATG, ATGAM, Thymoglobulin) stopped: _______ yyyy _______ mm _______ dd

ELSE GOTO (129) Were systemic corticosteroids given as therapy?

129 Were systemic corticosteroids given as therapy?
  O yes
  O no

IF (129) Were systemic corticosteroids given as therapy?:= no
THEN GOTO (132) Were topical corticosteroids given as therapy?
ELSE GOTO (130) Systemic corticosteroids stopped?

130 Were systemic corticosteroids stopped?
  O yes
  O no

IF (130) Systemic corticosteroids stopped?:= no
THEN GOTO (132) Were topical corticosteroids given as therapy?
ELSE GOTO (131) Date therapeutic systemic corticosteroids stopped unknown

131 □ Date therapeutic systemic corticosteroids stopped unknown
    IF (131) Date therapeutic systemic corticosteroids stopped unknown:= checked
    THEN GOTO (132) Were topical corticosteroids given as therapy?
    ELSE GOTO date estimated

□ date estimated
ELSE GOTO Date stopped

Date systemic corticosteroids stopped: _____ YYYY - MM - DD

ELSE GOTO (132) Were topical corticosteroids given as therapy?

132 Were topical corticosteroids given as therapy?
   O yes
   O no

IF (132) Were topical corticosteroids given as therapy?:= no
THEN GOTO (135) Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?
ELSE GOTO (133) Topical corticosteroids stopped?

133 Were therapeutic topical corticosteroids stopped?
   O yes
   O no

IF (133) Topical corticosteroids stopped?:= no
THEN GOTO (135) Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?
ELSE GOTO (134) Date therapeutic topical corticosteroids stopped unknown

134 □ Date therapeutic topical corticosteroids stopped unknown
    IF (134) Date therapeutic topical corticosteroids stopped unknown:= checked
    THEN GOTO (135) Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?
    ELSE GOTO date estimated

□ date estimated
ELSE GOTO Date stopped

Date therapeutic topical corticosteroids stopped: _____ YYYY - MM - DD

ELSE GOTO (135) Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?

135 Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?
   O yes
   O no

IF (135) Was cyclophosphamide (CTX, Cytoxan, Neosar) given as therapy?:= no
THEN GOTO (138) Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?
ELSE GOTO (136) Cyclophosphamide stopped?

136 Was therapeutic cyclophosphamide (CTX, Cytoxan, Neosar) stopped?
   O yes
IF (136) Cyclophosphamide stopped?:= no
THEN GOTO (138) Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?
ELSE GOTO (137) Date therapeutic cyclophosphamide (CTX, Cytoxan, Neosar) stopped unknown

137  Date therapeutic cyclophosphamide (CTX, Cytoxan, Neosar) stopped unknown
    IF (137) Date therapeutic cyclophosphamide (CTX, Cytoxan, Neosar) stopped unknown:=
          checked
    THEN GOTO (138) Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?
    ELSE GOTO date estimated

Date therapeutic cyclophosphamide (CTX, Cytoxan, Neosar) stopped: __ __ __ __ - __ - __
    YYY Y MM DD
ELSE GOTO (138) Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?

138  Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?
    O yes
    O no
    IF (138) Was cyclosporine (CsA, Neoral, Sandimmune) given as therapy?:= no
    THEN GOTO (141) Was in vivo monoclonal antibody given as therapy?
    ELSE GOTO (139) Cyclosporine stopped?

139  Was therapeutic cyclosporine (CsA, Neoral, Sandimmune) stopped?
    O yes
    O no
    IF (139) Cyclosporine stopped?:= no
    THEN GOTO (141) Was in vivo monoclonal antibody given as therapy?
    ELSE GOTO (140) Date therapeutic cyclosporine (CsA, Neoral, Sandimmune) stopped unknown

140  Date therapeutic cyclosporine (CsA, Neoral, Sandimmune) stopped unknown
    IF (140) Date therapeutic cyclosporine (CsA, Neoral, Sandimmune) stopped unknown:=
          checked
    THEN GOTO (141) Was in vivo monoclonal antibody given as therapy?
    ELSE GOTO date estimated

Date therapeutic cyclosporine (CsA, Neoral, Sandimmune) stopped? __ __ __ __ - __ - __
    YYY Y MM DD
ELSE GOTO (141) Was in vivo monoclonal antibody given as therapy?

141  Was in vivo monoclonal antibody given as therapy?
    O yes
    O no
    IF (141) Was in vivo monoclonal antibody given as therapy?:= no
    THEN GOTO (161) Was mycophenolate mofetil (MMF, Cellcept) given as therapy?
ERROR CORRECTION FORM

CIBMTR Center Number: _________________________ CIBMTR Recipient ID: ____________________________

Today’s Date: ___________ Infusion Date: ___________ CIBMTR Center Number: ___________

Month Day Year Month Day Year

CIBMTR Form 2031 revision 3 (page 42 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and
The Medical College of Wisconsin, Inc. All rights reserved.

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).
148 Was etanercept (Enbrel) given as therapy?
   O yes
   O no
   IF (148) Was etanercept (Enbrel) given as therapy?:= no
   THEN GOTO (151) Was infliximab (anti-TNF-α, Remicade) given as therapy?
   ELSE GOTO (149) Etanercept stopped?

149 Was therapeutic etanercept (Enbrel) stopped?
   O yes
   O no
   IF (149) Etanercept stopped?:= no
   THEN GOTO (151) Was infliximab (anti-TNF-α, Remicade) given as therapy?
   ELSE GOTO (150) Date therapeutic etanercept (Enbrel) stopped unknown

150 Date therapeutic etanercept (Enbrel) stopped unknown
   IF (150) Date therapeutic etanercept (Enbrel) stopped unknown:= checked
   THEN GOTO (151) Was infliximab (anti-TNF-α, Remicade) given as therapy?
   ELSE GOTO date estimated
   ELSE GOTO Date stopped

151 Was infliximab (anti-TNF-α, Remicade) given as therapy?
   O yes
   O no
   IF (151) Was infliximab (anti-TNF-α, Remicade) given as therapy?:= no
   THEN GOTO (154) Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?
   ELSE GOTO (152) Infliximab stopped?

152 Was therapeutic infliximab (anti-TNF-α, Remicade) stopped?
   O yes
   O no
   IF (152) Infliximab stopped?:= no
   THEN GOTO (154) Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?
<table>
<thead>
<tr>
<th>CIBMTR Center Number:</th>
<th>CIBMTR Recipient ID:</th>
<th>Initials:</th>
</tr>
</thead>
</table>

**Today's Date:**
- [ ] Month
- [ ] Day
- [ ] Year

**Infusion Date:**
- [ ] Month
- [ ] Day
- [ ] Year

**CIBMTR Center Number:**

---

**ELSE GOTO (153) Date therapeutic infliximab (anti-TNF-α, Remicade) stopped unknown**

153 [ ] Date therapeutic infliximab (anti-TNF-α, Remicade) stopped unknown
   
   IF (153) Date therapeutic infliximab (anti-TNF-α, Remicade) stopped unknown:= checked
   
   THEN GOTO (154) Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?
   
   ELSE GOTO date estimated

   [ ] date estimated
   
   ELSE GOTO Date stopped

   Date therapeutic infliximab (anti-TNF-α, Remicade) stopped: __ __ __ __ __ __ __ __ __ __

   ELSE GOTO (154) Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?

154 [ ] Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?

   [ ] yes
   
   [ ] no

   IF (154) Was rituximab (anti-CD20, Rituxan, MabThera) given as therapy?:= no
   
   THEN GOTO (157) Was any other monoclonal antibody given as therapy?
   
   ELSE GOTO (155) Rituximab stopped?

155 [ ] Was therapeutic rituximab (anti-CD20, Rituxan, MabThera) stopped?

   [ ] yes
   
   [ ] no

   IF (155) Rituximab stopped?:= no
   
   THEN GOTO (157) Was any other monoclonal antibody given as therapy?
   
   ELSE GOTO (156) Date therapeutic rituximab (anti-CD20, Rituxan, MabThera) stopped unknown

156 [ ] Date therapeutic rituximab (anti-CD20, Rituxan, MabThera) stopped unknown

   IF (156) Date therapeutic rituximab (anti-CD20, Rituxan, MabThera) stopped unknown:= checked
   
   THEN GOTO (157) Was any other monoclonal antibody given as therapy?
   
   ELSE GOTO date estimated

   [ ] date estimated
   
   ELSE GOTO Date stopped

   Date therapeutic rituximab (anti-CD20, Rituxan, MabThera) stopped: __ __ __ __ __ __ __ __ __ __

   ELSE GOTO (157) Was any other monoclonal antibody given as therapy?

157 [ ] Was any other monoclonal antibody given as therapy?

   [ ] yes

---

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).
IF (157) Was any other monoclonal antibody given as therapy?: = no
THEN GOTO (161) Was mycophenolate mofetil (MMF, Cellcept) given as therapy?
ELSE GOTO (158) Other monoclonal antibody stopped?

158 Was therapeutic other monoclonal antibody stopped?
   O yes
   O no
IF (158) Other monoclonal antibody stopped?: = no
THEN GOTO (160) Specify other monoclonal antibody:
ELSE GOTO (159) Date therapeutic other monoclonal antibody stopped unknown

159 □ Date therapeutic other monoclonal antibody stopped unknown
   IF (159) Date therapeutic other monoclonal antibody stopped unknown:= checked
   THEN GOTO (160) Specify other monoclonal antibody:
   ELSE GOTO date estimated

date estimated
ELSE GOTO Date stopped
Date therapeutic other monoclonal antibody stopped: _______ YYYY _______ MM _______ DD

ELSE GOTO (160) Specify other monoclonal antibody:

160 Specify other monoclonal antibody: __________________________

ELSE GOTO (161) Was mycophenolate mofetil (MMF, Cellcept) given as therapy?

161 Was mycophenolate mofetil (MMF, Cellcept) given as therapy?
   O yes
   O no
IF (161) Was mycophenolate mofetil (MMF, Cellcept) given as therapy?: = no
THEN GOTO (164) Was tacrolimus (FK506, Prograf) given as therapy?
ELSE GOTO (162) Mycophenolate mofetil stopped?

162 Was therapeutic mycophenolate mofetil (MMF, Cellcept) stopped?
   O yes
   O no
IF (162) Mycophenolate mofetil stopped?: = no
THEN GOTO (164) Was tacrolimus (FK506, Prograf) given as therapy?
ELSE GOTO (163) Date therapeutic mycophenolate mofetil (MMF, Cellcept) stopped unknown

163 □ Date therapeutic mycophenolate mofetil (MMF, Cellcept) stopped unknown
   IF (163) Date therapeutic mycophenolate mofetil (MMF, Cellcept) stopped unknown:= checked

CIBMTR Form 2031 revision 3 (page 45 of 50) Last Updated November 29, 2012.
Copyright (c) 2012 National Marrow Donor Program and
The Medical College of Wisconsin, Inc. All rights reserved.

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).
THEN GOTO (164) Was tacrolimus (FK506, Prograf) given as therapy?
ELSE GOTO date estimated

Date therapeutic mycophenolate mofetil (MMF, Cellcept) stopped:

ELSE GOTO (164) Was tacrolimus (FK506, Prograf) given as therapy?

164  Was tacrolimus (FK506, Prograf) given as therapy?
    O  yes
    O  no
IF (164) Was tacrolimus (FK506, Prograf) given as therapy? := no
THEN GOTO (167) Was any other immunosuppressive drug given as therapy?
ELSE GOTO (165) Tacrolimus stopped?

165  Was therapeutic tacrolimus (FK506, Prograf) stopped?
    O  yes
    O  no
IF (165) Tacrolimus stopped? := no
THEN GOTO (167) Was any other immunosuppressive drug given as therapy?
ELSE GOTO (166) Date therapeutic tacrolimus (FK506, Prograf) stopped unknown

166  Date therapeutic tacrolimus (FK506, Prograf) stopped unknown
    O  yes
    O  no
IF (166) Date therapeutic tacrolimus (FK506, Prograf) stopped unknown := checked
THEN GOTO (167) Was any other immunosuppressive drug given as therapy?
ELSE GOTO date estimated

ELSE GOTO (167) Was any other immunosuppressive drug given as therapy?

167  Was any other immunosuppressive drug given as therapy?
    O  yes
    O  no
IF (167) Was any other immunosuppressive drug given as therapy? := no
THEN GOTO (171) Was gene therapy performed (between diagnosis and prior to the preparative regimen)?
ELSE GOTO (168) Other immunosuppressive drug stopped?

168  Was therapeutic other immunosuppressive drugs stopped?
    O  yes
    O  no
IF (168) Other immunosuppressive drug stopped? := no
THEN GOTO (170) Specify other immunosuppressive drug:
ELSE GOTO (169) Date other therapeutic immunosuppressive drug stopped unknown
**ERROR CORRECTION FORM**

CIBMTR Center Number: __________________________ CIBMTR Recipient ID: ____________________________

<table>
<thead>
<tr>
<th>Sequence Number:</th>
<th>CIBMTR Recipient ID:</th>
<th>Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>Infusion Date:</th>
<th>CIBMTR Center Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month Day Year</td>
<td>Month Day Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIBMTR Center Number:</th>
<th>CIBMTR Recipient ID:</th>
</tr>
</thead>
</table>

Table:

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>169</td>
<td>Date other therapeutic immunosuppressive drug stopped unknown</td>
<td>□ date estimated</td>
</tr>
<tr>
<td>170</td>
<td>Specify other immunosuppressive drug</td>
<td></td>
</tr>
<tr>
<td>171</td>
<td>Was gene therapy performed (between diagnosis and prior to the preparative regimen)?</td>
<td>□ yes □ no</td>
</tr>
<tr>
<td>172</td>
<td>Specify date of infusion of gene therapy</td>
<td></td>
</tr>
<tr>
<td>173</td>
<td>Was the recipient considered to have failed gene therapy?</td>
<td>□ yes □ no</td>
</tr>
<tr>
<td>174</td>
<td>Did the recipient receive any other significant treatment(s) (between diagnosis and prior to the preparative regimen)?</td>
<td>□ yes □ no</td>
</tr>
<tr>
<td>175</td>
<td>Specify other treatment(s):</td>
<td></td>
</tr>
<tr>
<td>176</td>
<td>Did the recipient receive parenteral nutrition (between diagnosis and prior to the preparative regimen)?</td>
<td>□ yes □ no</td>
</tr>
</tbody>
</table>

CIBMTR Form 2031 revision 3 (page 47 of 50) Last Updated November 29, 2012.

Copyright (c) 2012 National Marrow Donor Program and
The Medical College of Wisconsin, Inc. All rights reserved.

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).
ELSE GOTO (177) Did the recipient receive mechanical ventilation (between diagnosis and prior to the preparative regimen)?

177 Did the recipient receive mechanical ventilation (between diagnosis and prior to the preparative regimen)?
   O yes
   O no
ELSE GOTO (178) Were any biologic specimens collected for this recipient (between diagnosis and prior to the preparative regimen)?

178 Were any biologic specimens collected for this recipient (between diagnosis and prior to the preparative regimen)?
   O yes
   O no
   O unknown
IF (178) Were any biologic specimens collected for this recipient (between diagnosis and prior to the preparative regimen)?:= yes THEN GOTO (179) DNA ELSE GOTO First name

ELSE GOTO First name

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

179 DNA
   O yes
   O no
ELSE GOTO (180) Epstein-Barr virus (EBV)-transformed B-Cell line

180 Epstein-Barr virus (EBV)-transformed B-Cell line
   O yes
   O no
ELSE GOTO (181) Fibroblast cell line

181 Fibroblast cell line
   O yes
   O no
ELSE GOTO (182) Herpes virus saimiri-transformed T-cell line

182 Herpes virus saimiri-transformed T-cell line
   O yes
   O no
ELSE GOTO (183) Other T-cell line

183 Other T-cell line
   O yes
   O no
ELSE GOTO (184) Pathological specimen

184 Pathological specimen
   O yes
   O no
IF (184) Pathological specimen:= no THEN GOTO (186) Peripheral blood mononuclear cells (PBMC), frozen
ELSE GOTO (185) Specify pathological specimen(s):

185 Specify pathological specimen(s): ________________

ELSE GOTO (186) Peripheral blood mononuclear cells (PBMC), frozen

186 Peripheral blood mononuclear cells (PBMC), frozen
   O yes
   O no

ELSE GOTO (187) RNA

187 RNA
   O yes
   O no

IF (187) RNA := no
THEN GOTO (189) Serum (pre-IVIG)
ELSE GOTO (188) Specify RNA source:

188 Specify RNA source: ________________

ELSE GOTO (189) Serum (pre-IVIG)

189 Serum (pre-IVIG)
   O yes
   O no

ELSE GOTO (190) Other specimen

190 Other specimen
   O yes
   O no

IF (190) Other specimen := no
THEN GOTO First name
ELSE GOTO (191) Specify other specimen(s):

191 Specify other specimen(s): ________________

ELSE GOTO First name

First Name: ____________________________
ELSE GOTO Last name

Last Name: ____________________________
ELSE GOTO Phone number:

Phone number: _________________________
ELSE GOTO Fax number:

Fax number: __________________________
ELSE GOTO E-mail address:

E-mail address: ________________________
ELSE GOTO End of Form