ERROR CORRECTION FORM

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

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

Initials: | |

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

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

CIBMTR Center Number: | | | | | |

CIBMTR
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Human Immunodeficiency Virus Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: | | | | | |

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

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

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

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.

All questions refer to the period prior to the preparative regimen for the recipient's first HSCT.

1. What was the date of diagnosis of Human Immunodeficiency Virus? Month | | Day | | | | Year

2. When was the diagnosis of HIV infection made relative to diagnosis of primary disease?
   1 ☐ prior to diagnosis of disease for which HSCT was performed
   2 ☐ at the time of diagnosis of disease for which HSCT was performed
   3 ☐ between diagnosis of disease for HSCT and workup for HSCT
   4 ☐ incidental detection during HSCT workup
   5 ☐ unknown

3. Was the disease for which the HSCT was performed considered HIV-associated (i.e., due to the presence of HIV infection)?
   1 ☐ yes
   2 ☐ no

4. Did the recipient have a history of opportunistic infections prior to the preparative regimen for HSCT?
   1 ☐ yes → Specify prior infection(s):
   2 ☐ no

   5. Cytomegalovirus (CMV) disease
      1 ☐ yes → Specify site(s) of CMV:
      2 ☐ no

      6. 1 ☐ yes 2 ☐ no Blood / buffy coat (i.e., antigenemia or viremia)
      7. 1 ☐ yes 2 ☐ no Gastrointestinal tract
      8. 1 ☐ yes 2 ☐ no Pneumonia
      9. 1 ☐ yes 2 ☐ no Retina
      10. 1 ☐ yes 2 ☐ no Other site → 11. If yes, specify other CMV site: _____

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

Internal use: Document number F00567 revision 2 Replaces: F00567 version 1.0 July 2007

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

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CIBMTR Center Number: | | | | | |

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12. Invasive fungal infection
    1 ☐ yes → Specify species of invasive fungal infection:
    2 ☐ no
    13. 1 ☐ yes 2 ☐ no Aspergillus
    14. 1 ☐ yes 2 ☐ no Candida
    15. 1 ☐ yes 2 ☐ no Other species → 16. If yes, specify other fungus: _____

17. Pneumocystis carnii pneumonia (PCP, PJP)
    1 ☐ yes
    2 ☐ no

18. Other infection
    1 ☐ yes → 19. Specify other infection: _____
    2 ☐ no

History of Anti-Retroviral Therapy

20. Did the recipient receive anti-retroviral therapy prior to HSCT?
    1 ☐ yes → **Continue with table below**
    2 ☐ no → **Continue with question 124**

Therapy Given?	Date Started (Month / Day / Year)	Currently Receiving?	Therapy Stopped?	Date Stopped (Month / Day / Year)	Reason Stopped (Code)
21. Abacavir (Ziagen) 1 ☐ yes 2 ☐ no	22.	23. 1 ☐ yes 2 ☐ no	24. 1 ☐ yes 2 ☐ no	25.	26.
27. Atazanavir (Reyataz) 1 ☐ yes 2 ☐ no	28.	29. 1 ☐ yes 2 ☐ no	30. 1 ☐ yes 2 ☐ no	31.	32.
33. Didanosine (ddl, Videx) 1 ☐ yes 2 ☐ no	34.	35. 1 ☐ yes 2 ☐ no	36. 1 ☐ yes 2 ☐ no	37.	38.
39. Efavirenz (Sustiva) 1 ☐ yes 2 ☐ no	40.	41. 1 ☐ yes 2 ☐ no	42. 1 ☐ yes 2 ☐ no	43.	44.
45. Emtricitabine (Emtriva) 1 ☐ yes 2 ☐ no	46.	47. 1 ☐ yes 2 ☐ no	48. 1 ☐ yes 2 ☐ no	49.	50.
51. Fosamprenavir (Lexiva) 1 ☐ yes 2 ☐ no	52.	53. 1 ☐ yes 2 ☐ no	54. 1 ☐ yes 2 ☐ no	55.	56.
57. Indinavir (Crixivan) 1 ☐ yes 2 ☐ no	58.	59. 1 ☐ yes 2 ☐ no	60. 1 ☐ yes 2 ☐ no	61.	62.
63. Lanuvudine (Epivir, Epzicom, 3TC) 1 ☐ yes 2 ☐ no	64.	65. 1 ☐ yes 2 ☐ no	66. 1 ☐ yes 2 ☐ no	67.	68.

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

CIBMTR Center Number: | | | | | |

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

Therapy Given?	Date Started (Month / Day / Year)	Currently Receiving?	Therapy Stopped?	Date Stopped (Month / Day / Year)	Reason Stopped (Code)
69. Lopinavir / ritonavir (Kaletra) 1 ☐ yes → 70. 2 ☐ no	70.	71. 1 ☐ yes 2 ☐ no	72. 1 ☐ yes → 73. 2 ☐ no	73.	74.
75. Nelfinavir (Viracept) 1 ☐ yes → 76. 2 ☐ no	76.	77. 1 ☐ yes 2 ☐ no	78. 1 ☐ yes → 79. 2 ☐ no	79.	80.
81. Nevirapine (Viramune) 1 ☐ yes → 82. 2 ☐ no	82.	83. 1 ☐ yes 2 ☐ no	84. 1 ☐ yes → 85. 2 ☐ no	85.	86.
87. Ritonavir (Norvir) 1 ☐ yes → 88. 2 ☐ no	88.	89. 1 ☐ yes 2 ☐ no	90. 1 ☐ yes → 91. 2 ☐ no	91.	92.
93. Saquinavir (Fortovase, Invirase) 1 ☐ yes → 94. 2 ☐ no	94.	95. 1 ☐ yes 2 ☐ no	96. 1 ☐ yes → 97. 2 ☐ no	97.	98.
99. Stavudine (Zerit, d4t) 1 ☐ yes → 100. 2 ☐ no	100.	101. 1 ☐ yes 2 ☐ no	102. 1 ☐ yes → 103. 2 ☐ no	103.	104.
105. Tenofovir (Truvada, Viread) 1 ☐ yes → 106. 2 ☐ no	106.	107. 1 ☐ yes 2 ☐ no	108. 1 ☐ yes → 109. 2 ☐ no	109.	110.
111. Zidovudine (Combivir, Retrovir, Trizivir, AZT) 1 ☐ yes → 112. 2 ☐ no	112.	113. 1 ☐ yes 2 ☐ no	114. 1 ☐ yes → 115. 2 ☐ no	115.	116.
117. Other anti-retroviral therapy 1 ☐ yes → 118. Specify other therapy: _____ 2 ☐ no	119.	120. 1 ☐ yes 2 ☐ no	121. 1 ☐ yes → 122. 2 ☐ no	122.	123.

Codes for Anti-Retroviral Therapy Stopped

1 Planned stop **2** Undesirable side effects **3** Other reason **4** Reason unknown

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Today's Date: Month / Day / 20 Year

Infusion Date: Month / Day / 20 Year

CIBMTR Center Number:

CIBMTR Center Number: | CIBMTR Recipient ID:

Serological Evidence of HIV Exposure / Infection

Provide all documented CD4 counts obtained within 3 months prior to the preparative regimen. If no values were obtained in the 3 months prior to the preparative regimen, provide and date the most recent values obtained prior to the preparative regimen.

	Month	Day	Year			Specify exponent:
124. Date:			20	125. CD4 counts:	.	x 10
126. Date:			20	127. CD4 counts:	.	x 10
128. Date:			20	129. CD4 counts:	.	x 10
130. Date:			20	131. CD4 counts:	.	x 10
132. Date:			20	133. CD4 counts:	.	x 10

Provide all documented HIV viral load levels obtained within 3 months prior to the preparative regimen. If no values were obtained in the 3 months prior to the preparative regimen, provide and date the most recent values obtained prior to the preparative regimen.

	Month	Day	Year		Specify units:
134. Date:			20	135. HIV viral load level: , , .	1 ☐ copies/mL 2 ☐ log_{10}/mL
136. Date:			20	137. HIV viral load level: , , .	1 ☐ copies/mL 2 ☐ log_{10}/mL
138. Date:			20	139. HIV viral load level: , , .	1 ☐ copies/mL 2 ☐ log_{10}/mL
140. Date:			20	141. HIV viral load level: , , .	1 ☐ copies/mL 2 ☐ log_{10}/mL
142. Date:			20	143. HIV viral load level: , , .	1 ☐ copies/mL 2 ☐ log_{10}/mL

144. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

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