1. What was the date of diagnosis of Human Immunodeficiency Virus?

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
   2. no

Specify prior infection(s):

5. Cytomegalovirus (CMV) disease
   1. yes
   2. no

Specify site(s) of CMV:
   1. Blood / buffy coat (i.e., antigenemia or viremia)
   2. Gastrointestinal tract
   3. Pneumonia
   4. Retina
   5. Other site

11. If yes, specify other CMV site:

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.
12. Invasive fungal infection
   1 yes 2 no
   Specify species of invasive fungal infection:
   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 carinii pneumonia (PCP, PJP)
   1 yes 2 no

18. Other infection
   1 yes 2 no
   Specify other infection:

History of Anti-Retroviral Therapy

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

<table>
<thead>
<tr>
<th>Therapy Given?</th>
<th>Date Started</th>
<th>Currently Receiving?</th>
<th>Therapy Stopped?</th>
<th>Date Stopped</th>
<th>Reason Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month Day Year</td>
<td>yes no</td>
<td>Month Day Year</td>
<td>yes no</td>
<td>Month Day Year</td>
</tr>
<tr>
<td>27. Atazanavir (Reyataz)</td>
<td>28.</td>
<td>yes no</td>
<td>29. 1 yes 2 no</td>
<td>30. 1 yes 2 no</td>
<td>31.</td>
</tr>
<tr>
<td>33. Didanosine (ddl, Videx)</td>
<td>34.</td>
<td>yes no</td>
<td>35. 1 yes 2 no</td>
<td>36. 1 yes 2 no</td>
<td>37.</td>
</tr>
<tr>
<td>39. Efavirenz (Sustiva)</td>
<td>40.</td>
<td>yes no</td>
<td>41. 1 yes 2 no</td>
<td>42. 1 yes 2 no</td>
<td>43.</td>
</tr>
<tr>
<td>45. Emtricitabine (Emtriva)</td>
<td>46.</td>
<td>yes no</td>
<td>47. 1 yes 2 no</td>
<td>48. 1 yes 2 no</td>
<td>49.</td>
</tr>
<tr>
<td>51. Fosamprenavir (Lexiva)</td>
<td>52.</td>
<td>yes no</td>
<td>53. 1 yes 2 no</td>
<td>54. 1 yes 2 no</td>
<td>55.</td>
</tr>
<tr>
<td>57. Indinavir (Crixivan)</td>
<td>58.</td>
<td>yes no</td>
<td>59. 1 yes 2 no</td>
<td>60. 1 yes 2 no</td>
<td>61.</td>
</tr>
<tr>
<td>63. Lanuvudine (Epivir, Epzicom, 3TC)</td>
<td>64.</td>
<td>yes no</td>
<td>65. 1 yes 2 no</td>
<td>66. 1 yes 2 no</td>
<td>67.</td>
</tr>
<tr>
<td>Therapy Given</td>
<td>Date Started</td>
<td>Currently Receiving</td>
<td>Therapy Stopped</td>
<td>Date Stopped</td>
<td>Reason Stopped</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>69. Lopinavir / ritonavir (Kaletra)</td>
<td>70/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>73/1/2020</td>
<td>74</td>
</tr>
<tr>
<td>75. Nelfinavir (Viracept)</td>
<td>76/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>79/1/2020</td>
<td>80</td>
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<tr>
<td>81. Nevirapine (Viramune)</td>
<td>82/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>85/1/2020</td>
<td>86</td>
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<tr>
<td>87. Ritonavir (Norvir)</td>
<td>88/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>91/1/2020</td>
<td>92</td>
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<tr>
<td>93. Saquinavir (Fortovase, Invirase)</td>
<td>94/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>97/1/2020</td>
<td>98</td>
</tr>
<tr>
<td>99. Stavudine (Zerit, d4t)</td>
<td>100/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>103/1/2020</td>
<td>104</td>
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<tr>
<td>105. Tenofovir (Truvada, Viread)</td>
<td>106/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>109/1/2020</td>
<td>110</td>
</tr>
<tr>
<td>111. Zidovudine (Combivir, Retrovir, Trizivir, AZT)</td>
<td>112/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>115/1/2020</td>
<td>116</td>
</tr>
<tr>
<td>117. Other anti-retroviral therapy</td>
<td>119/1/2020</td>
<td>yes</td>
<td>yes</td>
<td>122/1/2020</td>
<td>123</td>
</tr>
</tbody>
</table>

**Codes for Anti-Retroviral Therapy Stopped**

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

- [Date: ] [CD4 counts: ]
- [Date: ] [CD4 counts: ]
- [Date: ] [CD4 counts: ]
- [Date: ] [CD4 counts: ]
- [Date: ] [CD4 counts: ]
- [Date: ] [CD4 counts: ]

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.

- [Date: ] [HIV viral load level: ]
- [Date: ] [HIV viral load level: ]
- [Date: ] [HIV viral load level: ]
- [Date: ] [HIV viral load level: ]
- [Date: ] [HIV viral load level: ]
- [Date: ] [HIV viral load level: ]

[Specify units: ]
- 1 copies/mL
- 2 log/mL

Signed: ____________________________
Person completing form

Please print name: ____________________________

Phone: (__________) ____________________________

Fax: (__________) ____________________________

E-mail address: ____________________________