**Form 2100 R3.0: 100 Days Post-HSCT Data**

**Center:** 

**CRID:**

### Key Fields

- **Sequence Number:**
- **Date Received:** __ __ __ __ - __ __ - __ __
- **CIBMTR Center Number:**
- **CIBMTR Recipient ID:**
- **Today's Date:** __ __ __ __ - __ __ - __ __
- **Date of HSCT for which this form is being completed:** __ __ __ __ - __ __ - __ __
- **HSCT type (check all that apply):**
  - Autologous
  - Allogeneic, unrelated
  - Allogeneic, related
  - Syngeneic (identical twin)
- **Product type (check all that apply):**
  - Marrow
  - PBSC
  - Cord blood
  - multiple cord blood units infused
  - Other product
    - Specify: _______________________

### Vital Status

**Questions: 1 - 7**

1. **Date of actual contact with the recipient to determine medical status for this follow-up report:** __ __ __ __ - __ __ - __ __

2. **Did this patient receive the scheduled HSCT?**
   - yes
   - no

3. **Reason:**
   - patient died between start of preparative regimen and HSCT
   - HSCT was canceled, but patient is alive

4. **Reason for cancellation:** _______________________

5. **Did recipient receive a subsequent HSCT (bone marrow, mobilized peripheral blood stem cells, cord blood) prior to day 100 after the HSCT for which this form is being completed?**
   - yes
   - no

6. **Specify the recipient's survival status at the date of actual contact:**
   - Alive
   - Dead

7. **Has the recipient received a donor cellular infusion (DCI)?**
   - yes
   - no
## Hematopoietic Reconstitution Post-HSCT

Questions: 8 - 33

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>Did the recipient receive hematopoietic, lymphoid growth factors or cytokines after the start of the preparatory regimen?</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td>Specify agents and provide dates for the first course of each agent given in this reporting period.</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>Date G-CSF therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td>Specify drug given: Neupogen Neulasta Lenograstim</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td>Date GM-CSF therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td>Erythropoietin</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td>Date therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td>Specify drug given: Epogen Aranesp (darbepoetin alfa)</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>KGF (palifermin, Kepivance) (If used for GVHD prophylaxis, report at question 118.)</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td>Date KGF therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td>Velafermin (If used for GVHD prophylaxis, report at question 120).</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td>Date velafermin therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td>Blinded growth factor or cytokine trial</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td></td>
<td>Specify study agent: ___________________________</td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td>Date therapy started: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td>Therapy: ___________________________</td>
</tr>
</tbody>
</table>
**Granulopoiesis/Neutrophil Recovery**

**Questions: 34 - 43**

30 Other agent:
- [ ] yes  
- [ ] no

31 Specify other agent: 

32 Date other therapy started: __ __ __ __ / __ __ / __ __

33 Therapy: 

34 Is (was) there evidence of hematopoietic recovery following the initial HSCT? (check only one)
- [ ] Yes, ANC $\geq$ 500/mm$^3$ achieved and sustained for 3 lab values * with no subsequent decline
- [ ] Yes, ANC $\geq$ 500/mm$^3$ for 3 lab values * with subsequent decline in ANC to < 500/mm$^3$ for >= 3 days
- [ ] No, ANC $\geq$ 500/mm$^3$ was not achieved * and there was no evidence of recurrent disease in the bone marrow
- [ ] No, ANC $\geq$ 500/mm$^3$ was not achieved * and there was documented persistent disease in the bone marrow post-HSCT
- [ ] ANC never dropped below 500/mm$^3$ at any time after the start of the preparative regimen

35 Date ANC $\geq$ 500/mm$^3$ (first of 3 lab values): * __ __ __ __ / __ __ / __ __

36 Date ANC $\geq$ 500/mm$^3$ (first of 3 lab values): * __ __ __ __ / __ __ / __ __

37 Date of decline in ANC to < 500/mm$^3$ for >= 3 days (first of 3 days that the ANC declined): * __ __ __ __ / __ __ / __ __

38 WBC: ___ ___ ___ ___ ___ ___ ___ ___ x 10$^9$L (x 10$^3$/mm$^3$)
- [ ] x 10$^9$L
- [ ] x 10$^6$L

39 Neutrophils: ___ ___ ___ ___ ___ ___ ___ ___ %

40 Did recipient recover and maintain ANC $\geq$ 500/mm$^3$ * following the decline?
- [ ] yes  
- [ ] no

41 Date of ANC recovery: __ __ __ __ / __ __ / __ __  
   Date of ANC recovery unknown

**CBC on first day of recovery:**

42 WBC: ___ ___ ___ ___ ___ ___ ___ ___ x 10$^9$L (x 10$^3$/mm$^3$)
- [ ] x 10$^9$L
- [ ] x 10$^6$L

43 Neutrophils: ___ ___ ___ ___ ___ ___ ___ ___ %

**Megakaryopoiesis/Platelet Recovery**

**Questions: 44 - 47**

44 Was an initial platelet count $\geq$ 20 x 10$^9$L achieved?
- [ ] Yes
- [ ] No  
   platelet count never dropped below 20 x 10$^9$L

45 Date platelets $\geq$ 20 x 10$^9$L: * __ __ __ __ / __ __ / __ __  
   date estimated  
   Date unknown
Form 2100 R3.0: 100 Days Post-HSCT Data

Current Hematologic Findings

46 Was an initial platelet count \( \geq 50 \times 10^9/L \) achieved?

- Yes
- No

platelet count never dropped below \( 50 \times 10^9/L \)

47 Date platelets \( \geq 50 \times 10^9/L \):

- Date estimated
- Date unknown

48 Date of most recent hematologic testing:

49 WBC: \( \quad \) \( \times 10^9/L \) \( \times 10^3/mm^3 \)

50 Neutrophils: \( \quad \) \%  

Neutrophils not tested

51 Lymphocytes: \( \quad \) \%  

Lymphocytes not tested

52 Hemoglobin:

- g/dL
- g/L
- mmol/L  

Hemoglobin not tested

53 Hematocrit:

- %

transfused RBS \( \leq 30 \) days from date of most current testing

54 Platelets:

- \( \quad \) \( \times 10^9/L \) \( \times 10^3/mm^3 \)

Platelets not tested

transfused platelets \( \leq 7 \) days from date of most current testing

Imune Reconstitution

Specify the immunoglobulin values from the most recent testing:

55 IgG:

- mg/dL
- g/dL
- g/L  

IgG not tested

56 Date tested:

57 IgM:

- mg/dL
- g/dL
- g/L  

IgM not tested

58 Date tested:

59 IgA:

- mg/dL
- g/dL
- g/L
IgA not tested

60 Date tested: __ __ __ __ - __ __ - __ __

61 Did the recipient receive supplemental intravenous immunoglobulins (IVIG)?

no

62 Was therapy ongoing within one month of immunoglobulin testing?

no

Indication(s) for use:

63 Prophylaxis for low IgG with no active infection (polyclonal IV gamma globulin / IVIG)

no

64 Prophylaxis for cytomegalovirus (CMV) infection (CMV / hyperimmune gamma globulin)

no

65 Treatment for CMV infection

no

66 Treatment for respiratory syncytial virus (RSV) infection

no

67 Treatment for infection with low IgG (not CMV or RSV)

no

68 Other indication

no

69 Specify other indication: __________________________

70 Were lymphocyte analyses performed?

no

71 Date of most recent testing performed: __ __ __ __ - __ __ - __ __

72 CD3 ______________________ x 10^9/L (x 10^3/mm^3)

x 10^6/L

CD3 not tested

73 CD4 ______________________ x 10^9/L (x 10^3/mm^3)

x 10^6/L

CD4 not tested

74 CD8 ______________________ x 10^9/L (x 10^3/mm^3)

x 10^6/L

CD8 not tested
Form 2100 R3.0: 100 Days Post-HSCT Data

Center: CRID:

75 CD20 ________________  

\[ \text{x } 10^9/L \times (10^9/\text{mm}^3) \]

\[ \text{x } 10^6/L \]

CD20 not tested

76 CD56 ________________  

\[ \text{x } 10^9/L \times (10^9/\text{mm}^3) \]

\[ \text{x } 10^6/L \]

CD56 not tested

Chimerism Studies  Questions: 77 - 102

77 Allogeneic HSCTs only: Were chimerism studies performed post-HSCT?  

\[ \text{yes} \]

\[ \text{no} \]

78 Are chimerism laboratory reports attached to this form?  

\[ \text{yes} \]

\[ \text{no} \]

79 Were infusions from more than one donor given?  

\[ \text{yes} \]

\[ \text{no} \]

80 Specify donor gender:  

\[ \text{male} \]

\[ \text{female} \]

Single Donor (1)  Questions: 81 - 90

Provide date(s), method(s) and other information for all chimerism studies performed prior to date of contact (question 1).

81 Date __ __ __ __ - __ __ - __ __

82 Method ____________________________

83 Specify: ____________________________

84 Cell type ____________________________

85 Specify: ____________________________

86 Total cells examined ____________________________

87 Number of donor cells ____________________________

88 Number of host cells ____________________________

89 Percent donor cells, quantitative method ____________________________  

\[ \text{Presence of donor cells was detected by non-quantitative method} \]

90 Percent host cells, quantitative method ____________________________  

\[ \text{Presence of host cells was detected by non-quantitative method} \]

Multiple Donors (1)  Questions: 91 - 102

91 NMDP Donor ID: ____________________________

-or-

Donor's / infant's date of birth: __ __ __ __ - __ __ - __ __

-or-

NMDP cord blood unit ID ____________________________
Non-NMDP unrelated donor ID: _____________________________

Non-NMDP cord blood unit ID: _____________________________

Donor's / infant's gender:

- [ ] male
- [ ] female

Date: __ __ __ __ - __ __ __

Method: _____________________________

Specify: _____________________________

Cell type: _____________________________

Specify: _____________________________

Total cells examined: _____________________________

Number of donor cells: _____________________________

Number of host cells: _____________________________

Percent donor cells, quantitative method: _____________________________

Presence of donor cells was detected by non-quantitative method

Percent host cells, quantitative method: _____________________________

Presence of host cells was detected by non-quantitative method

---

### Engraftment Syndrome

Questions: 103 - 109

103 Did engraftment syndrome occur?

- [ ] yes
- [ ] no

104 Date of onset: __ __ __ __ - __ __ __

Specify the symptoms of engraftment syndrome:

105 Capillary leak syndrome

- [ ] yes
- [ ] no

106 Fever

- [ ] yes
- [ ] no

107 Skin rash

- [ ] yes
- [ ] no

108 Specify amount of body surface area affected: _____________________________ %

109 Was engraftment syndrome treated with corticosteroids?

- [ ] yes
- [ ] no

---

### Acute Graft vs. Host Disease (GVHD)

Questions: 110 - 187

110 Was specific therapy used after the start of the preparative regimen to prevent acute GVHD or graft rejection (note: do not include growth factors reported in question 8, or ex vivo T-cell depletion reported on the Product Insert), or for autologous HSCT to induce acute GVHD?

- [ ] yes
- [ ] no
111 ALS, ALG, ATS, ATG
   yes   no

112 Specify source:
   Horse   Rabbit   Other

113 Specify source: _______________________

114 Corticosteroids (systemic)
   yes   no

115 Cyclosporine (CSA) (Sandimmune, Neoral)
   yes   no

116 ECP (extra-corporeal photopheresis)
   yes   no

117 FK 506 (Tacrolimus, Prograf)
   yes   no

118 KGF (palifermin, Kepivance) (If used to prevent mucositis, report at question 20.)
   yes   no

119 Specify date started: ___ ___ ___ ___ ___ ___

120 Velafermin (If used to prevent mucositis, report at question 23.)
   yes   no

121 Specify date started: ___ ___ ___ ___ ___ ___

122 In vivo monoclonal antibody
   yes   no

   Specify in vivo monoclonal antibody:

123 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
   yes   no

124 Specify: _______________________

125 Campath
   yes   no

126 Etanercept (Enbrel)
   yes   no

127 Infliximab (Remicade)
   yes   no

128 Other in vivo monoclonal antibody
   yes   no

129 Specify antibody: _______________________

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.
130 In vivo immunotoxin

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

131 Specify: __________________________

132 Methotrexate (MTX) (Amethopterin)

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

133 Mycophenolate mofetil (MMF) (CellCept)

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

134 Sirolimus (Rapamycin, Rapamune)

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

135 Ursodiol

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

136 Blinded randomized trial

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

137 Specify trial agent: __________________________

138 Other agent

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

139 Specify other agent: __________________________

140 Did acute GVHD occur?

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

acute GVHD persists from prior HSCT / DCI

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

141 Date of acute GVHD diagnosis: ____ ____ ____  Date is greater than 100 days; date is correct

142 Was the diagnosis based on evidence from a biopsy (histology)?

\[ \begin{array}{c}
\text{Yes} \\
\text{No}
\end{array} \]

143 Specify result(s):

\[ \begin{array}{cccc}
\text{Positive} & \text{Negative} & \text{Inconclusive} & \text{Not tested} \\
\text{GI} & & & \\
\text{Liver} & & & \\
\text{Lung} & & & \\
\text{Skin} & & & \\
\end{array} \]
147 Other site
   Positive  Negative  Inconclusive  Not tested

148 Specify other site: ____________________________

149 Is a copy of the pathology report attached?
   yes  no

150 Was the diagnosis based on clinical evidence?
   yes  no

151 Maximum overall grade of acute GVHD:
   I  II  III  IV

152 Is acute GVHD still present at the date of contact for this report (question 1)?
   Yes  No  progressed to chronic GVHD  Unknown

153 List the maximum severity of organ involvement:
   Skin
   no skin acute GVHD / rash not attributable to acute GVHD
   stage 0 – no rash
   stage 1 – maculopapular rash, < 25% of body surface
   stage 2 – maculopapular rash, 25–50% of body surface
   stage 3 – generalized erythroderma
   stage 4 – generalized erythroderma with bullae formation and desquamation

154 Lower intestinal tract: (use mL/day for adult recipients and mL/m²/day for pediatric recipients)
   no gut acute GVHD / diarrhea not attributable to acute GVHD
   Stage 0 – no diarrhea
   stage 0 – diarrhea <= 500 mL/day or < 280 mL/m²/day
   stage 1 – diarrhea > 500 but <= 1000 mL/day or 280-555 mL/m²/day
   stage 2 – diarrhea > 1000 but <= 1500 mL/day or 556-833 mL/m²/day
   stage 3 – diarrhea > 1500 mL/day or > 833 mL/m²/day
   stage 4 – severe abdominal pain, with or without ileus

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155 Upper intestinal tract:

- stage 0 - no persistent nausea or vomiting
- stage 1 - persistent nausea or vomiting

156 Liver

- no liver acute GVHD / bilirubin level not attributable to acute GVHD
- stage 0 - bilirubin < 2.0 mg/dL (< 34 µmol/L)
- stage 1 - bilirubin 2.0–3.0 mg/dL (34–52 µmol/L)
- stage 2 - bilirubin 3.1–6.0 mg/dL (53–103 µmol/L)
- stage 3 - bilirubin 6.1–15.0 mg/dL (104–256 µmol/L)
- stage 4 - bilirubin > 15.0 mg/dL (> 256 µmol/L)

157 Other clinical organ involvement?

- yes
- no

Specify site:

158 Lung

- yes
- no

159 Other site:

- yes
- no

160 Specify other site:

161 Was specific therapy used to treat acute GVHD?

- yes
- no

162 ALS, ALG, ATS, ATG

- yes
- no

163 Specify source:

- Horse
- Rabbit
- Other

164 Specify source:

165 Corticosteroids (systemic)

- yes
- no

166 Corticosteroids (topical)

- yes
- no

167 Cyclosporine (CSA) (Sandimmune, Neoral)

- yes
- no

168 ECP (extra-corporeal photopheresis)

- yes
- no
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>169 FK 506 (Tacrolimus, Prograf)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>170 In vivo monoclonal antibody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify in vivo monoclonal antibody:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>171 Anti CD25 (Zenapax, Daclizumab, AntiTAC)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>172 Specify anti CD25:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>173 Campath</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>174 Etanercept (Enbrel)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>175 Infliximab (Remicade)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>176 Other in vivo monoclonal antibody</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>177 Specify antibody:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>178 In vivo immunotoxin</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>179 Specify immunotoxin:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>180 Methotrexate (MTX) (Amethopterin)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>181 Mycophenolate mofetil (MMF) (CellCept)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>182 Sirolimus (Rapamycin, Rapamune)</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>183 Ursodiol</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>184 Blinded randomized trial</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>185 Specify trial agent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>186 Other agent</td>
<td>yes/no</td>
<td></td>
</tr>
<tr>
<td>187 Specify other agent:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.
Chronic Graft vs. Host Disease (GVHD)  Questions: 188 - 259

188 Has recipient developed clinical chronic GVHD?

- Yes
  - chronic GVHD persists from prior HSCT / DCI
- No
- Unknown

189 Date of chronic GVHD diagnosis: ___ ___ - ___ ___ Date is less than 100 days; date is correct

190 Onset of chronic GVHD was:

- Progressive (acute GVHD progressed directly to chronic GVHD)
- Interrupted (acute GVHD resolved, then chronic GVHD developed)
- De novo (acute GVHD never developed)
- chronic GVHD flare (symptoms reactivated within 30 days of drug tapering or discontinuation)

If the recipient is 16 years of age or older, complete the Karnofsky Scale. If the recipient is younger than 16 years of age, complete the Lansky Scale.

191 Karnofsky / Lansky score at diagnosis of chronic GVHD: ___________________________

192 Platelet count at diagnosis of chronic GVHD: _______ x 10^9/L (x 10^9/mm^3)

193 Diagnosis was based on:

- histologic evidence / biopsy proven
- Clinical evidence
- Both
- Unknown

194 Maximum grade of chronic GVHD:

- limited – localized skin involvement and/or hepatic dysfunction due to chronic GVHD
- extensive - one or more of the following:
  - generalized skin involvement; or,
  - liver histology showing chronic aggressive hepatitis, bridging necrosis or cirrhosis; or,
  - involvement of eye: Schirmer's test with < 5 mm wetting; or
  - involvement of minor salivary glands or oral mucosa demonstrated on labial biopsy; or
  - involvement of any other target organ
### Overall Severity of Chronic GVHD:

- **Mild** – signs and symptoms of chronic GVHD do not interfere substantially with function and do not progress once appropriately treated with local therapy or standard systemic therapy (corticosteroids and/or cyclosporine or FK 506)
- **Moderate** – signs and symptoms of chronic GVHD interfere somewhat with function despite appropriate therapy or are progressive through first line systemic therapy (corticosteroids and/or cyclosporine or FK 506)
- **Severe** – signs and symptoms of chronic GVHD limit function substantially despite appropriate therapy or are progressive through second line therapy

### Organ Involvement

Indicate if there was organ involvement with chronic GVHD from the list below:

<table>
<thead>
<tr>
<th>Organ Involvement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>196</strong> Sclerosis of skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>197</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>198</strong> Other skin or hair involvement (rash, ulcers, pruritus or itching, dyspigmentation, alopecia, lichenoid skin changes, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>199</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>200</strong> Eyes (xerophthalmia (dry eyes), abnormal Schirmer's test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>201</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>202</strong> Mouth (lichenoid changes, mucositis / ulcers, erythema, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>203</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>204</strong> Bronchiolitis obliterans</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>205</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>206</strong> Other lung involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>207</strong> Was involvement proven by biopsy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>208</strong> Gastrointestinal tract (esophageal involvement, chronic nausea / vomiting, chronic diarrhea, malabsorption, abdominal pain / cramps, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
209  Was involvement proven by biopsy?
   yes  no

210  Liver
   yes  no

211  Was involvement proven by biopsy?
   yes  no

212  Genitourinary tract (vaginitis / stricture, etc.)
   yes  no

213  Was involvement proven by biopsy?
   yes  no

214  Musculoskeletal (arthritis, contractures, myositis, myasthenia, etc.)
   yes  no

215  Was involvement proven by biopsy?
   yes  no

216  Thrombocytopenia (< 100 x 10^9/L)
   yes  no

217  Eosinophilia
   yes  no

218  Autoantibodies
   yes  no

219  Other hematologic involvement
   yes  no

220  Serositis
   yes  no

221  Was involvement proven by biopsy?
   yes  no

222  Weight loss
   yes  no

223  Other organ involvement from chronic GVHD
   yes  no

224  Specify site:  

225  Was involvement proven by biopsy?
   yes  no
226  Was specific therapy used to treat chronic GVHD?

  yes □  no □

Specify:

227  ALS, ALG, ATS, ATG

  yes □  no □

228  Specify source:

  Horse □  Rabbit □  Other □

229  Specify source: ____________________________

230  Azathioprine

  yes □  no □

231  Corticosteroids (systemic)

  yes □  no □

232  Corticosteroids (topical)

  yes □  no □

233  Cyclosporine (CSA) (Sandimmune, Neoral)

  yes □  no □

234  ECP (extracorporeal photopheresis)

  yes □  no □

235  Hydroxychloroquine (Plaquenil)

  yes □  no □

236  Etretinate

  yes □  no □

237  FK 506 (Tacrolimus, Prograf)

  yes □  no □

238  In vivo monoclonal antibody

  yes □  no □

Specify:

239  Anti CD 25 (Zenapax, Daclizumab, AntiTAC)

  yes □  no □

240  Specify anti CD25: ____________________________

241  Campath

  yes □  no □

242  Etanercept (Enbrel)

  yes □  no □
243 Infliximab (Remicade)  
   yes  no

244 Other in vivo monoclonal antibody  
   yes  no

245 Specify antibody: ______________________

246 Lamprene (Clofazimine)  
   yes  no

247 Mycophenolate mofetil (MMF) (CellCept)  
   yes  no

248 Pentostatin  
   yes  no

249 PUVA (Psoralen and UVA)  
   yes  no

250 Sirolimus (Rapamycin, Rapamune)  
   yes  no

251 Thalidomide  
   yes  no

252 Ursodiol  
   yes  no

253 Blinded randomized trial  
   yes  no

254 Specify trial agent: ______________________

255 Other agent:  
   yes  no

256 Specify other agent: ______________________

257 Are symptoms of chronic GVHD still present on the date of actual contact (or present at the time of death)?  
   yes  no

258 Is the recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD?  
   yes  no  Unknown

259 Date final treatment administered: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date unknown

---

**Infection**

Questions: 260 - 297

260 Did the recipient receive any of the following agents for infection prophylaxis after the start of the preparative regimen? (report prophylaxis immunoglobulins at questions 63–64)  
   yes  no  Unknown
<table>
<thead>
<tr>
<th>No.</th>
<th>Agent(s)</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>261</td>
<td>Systemic antibacterial antibiotics</td>
<td></td>
</tr>
<tr>
<td>262</td>
<td>Nonabsorbable oral antibiotics</td>
<td></td>
</tr>
<tr>
<td>263</td>
<td>Amphotericin (Fungizone) (non-lipid formulation)</td>
<td></td>
</tr>
<tr>
<td>264</td>
<td>Amphotericin (e.g. Abelcet, AmBisome, Amphotec) (lipid formulation)</td>
<td></td>
</tr>
<tr>
<td>265</td>
<td>Caspofungin</td>
<td></td>
</tr>
<tr>
<td>266</td>
<td>Fluconazole</td>
<td></td>
</tr>
<tr>
<td>267</td>
<td>Itraconazole</td>
<td></td>
</tr>
<tr>
<td>268</td>
<td>Micafungin</td>
<td></td>
</tr>
<tr>
<td>269</td>
<td>Posaconazole</td>
<td></td>
</tr>
<tr>
<td>270</td>
<td>Ravuconazole</td>
<td></td>
</tr>
<tr>
<td>271</td>
<td>Voriconazole</td>
<td></td>
</tr>
<tr>
<td>272</td>
<td>Other systemic antifungal agent</td>
<td></td>
</tr>
<tr>
<td>273</td>
<td>Specify other antifungal agent:</td>
<td></td>
</tr>
<tr>
<td>274</td>
<td>Acyclovir</td>
<td></td>
</tr>
<tr>
<td>275</td>
<td>Foscarnet</td>
<td></td>
</tr>
<tr>
<td>276</td>
<td>Ganciclovir (DHPG)</td>
<td></td>
</tr>
<tr>
<td>277</td>
<td>Valganciclovir (Valcyte)</td>
<td></td>
</tr>
</tbody>
</table>
278 Valacyclovir
   yes
   no

279 Other antiviral agent
   yes
   no

280 Specify other antiviral agent: ___________________________

281 Atovaquone (Mepron)
   yes
   no

282 Dapsone
   yes
   no

283 Pentamidine inhaled
   yes
   no

284 Pentamidine IV
   yes
   no

285 Trimethoprim/sulfamethoxazole (Bactrim/Septra)
   yes
   no

286 Other pneumocystis prophylaxis
   yes
   no

287 Specify other pneumocystis agent: ___________________________

288 Other prophylaxis agent
   yes
   no

289 Specify other prophylaxis agent: ___________________________

290 Did the recipient receive irradiated granulocyte infusions after the start of the preparative regimen to 60 days post-HSCT?
   yes
   no

291 Did the recipient develop a clinically significant infection after the start of the preparative regimen?
   yes
   no

Clinically significant infections (1) Questions: 292 - 295

Report each infection organism, site and date of diagnosis.

292 Organism ___________________________

The codes for "other organism, specify" should rarely be needed; check with your microbiology lab or HSCT physician before using them.

293 If other, specify: ___________________________

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

294 Site ___________________________

295 __ __ __ __ __ __ __ __
Form 2100 R3.0: 100 Days Post-HSCT Data

Center: CRID:

296 Did the recipient develop more than 7 infections post-HSCT?

   yes  no

297 Are extra pages attached?

   yes  no

Organ Function  Questions: 298 - 449

298 Did the recipient develop interstitial pneumonitis (IPn or ARDS) / idiopathic pneumonia syndrome (IPS) after the start of preparative regimen to date of last contact (question 1)?

Interstitial pneumonitis/idiopathic pneumonia syndrome is characterized on chest x-ray by hypoxia and diffuse interstitial infiltrates not caused by fluid overload.

(Report bacterial and fungal pneumonia in Infection section (questions 291-295))

   yes  no

   Pulmonary function (1)  Questions: 299 - 320

299 Date of diagnosis of IPn / IPS: __ __ __ __ - __ __ __ __

300 Were diagnostic tests done (other than radiographic studies)?

   yes  no

   Diagnosis was evaluated by:

301 bronchoalveolar lavage (BAL)
   yes  no

302 transbronchial biopsy
   yes  no

303 open / thorascopic (VATS) lung biopsy
   yes  no

304 autopsy
   yes  no

305 Other test
   yes  no

306 Specify other test: ____________________________

307 Was an organism isolated?

   Yes  no / idiopathic

   Etiology:

308 adenovirus
   yes  no

309 cytomegalovirus (CMV)
   yes  no

310 herpes simplex (HSV1, HSV2)
   yes  no
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>311 human herpes virus type 6 (HHV6)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>312 parainfluenza</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>313 respiratory syncytial virus (RSV)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>314 toxoplasma</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>315 other virus</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>316 Specify other virus:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>317 other organism</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>318 Specify organism:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>319 Did the recipient experience two or more episodes of IPn / IPS after the start of preparative regimen to date of last contact (question 1)?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>320 Are extra pages attached?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>321 Did the recipient develop non-infectious pulmonary abnormalities (other than IPn / IPS / ARDS) after the start of preparative regimen to date of last contact (question 1)?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>322 Did the recipient develop bronchiolitis obliterans after the start of preparative regimen to date of last contact (question 1)?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>323 Date of diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>324 Were diagnostic tests done?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Diagnosis was evaluated by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>325 bronchoalveolar lavage (BAL)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>326 transbronchial biopsy</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>327 open / thorascopic (VATS) lung biopsy</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
328 autopsy
   yes  no

329 Other
   yes  no

330 Specify: __________________________

331 Did the recipient develop pulmonary hemorrhage?
   yes  no

332 Date of diagnosis: ________ ________

333 Were diagnostic tests done?
   yes  no

   Diagnosis was evaluated by:

334 bronchoalveolar lavage (BAL)
   yes  no

335 transbronchial biopsy
   yes  no

336 open / thorascopic (VATS) lung biopsy
   yes  no

337 autopsy
   yes  no

338 Other
   yes  no

339 Specify: __________________________

340 Did the recipient develop cryptogenic organizing pneumonia (COP)?
   yes  no

341 Date of diagnosis: ________ ________

342 Were diagnostic tests done?
   yes  no

   Diagnosis was evaluated by:

343 bronchoalveolar lavage (BAL)
   yes  no

344 transbronchial biopsy
   yes  no

345 open / thorascopic (VATS) lung biopsy
   yes  no
346 autopsy
   yes [ ] no [ ]

347 Other
   yes [ ] no [ ]

348 Specify: ________________________________

349 Did the recipient develop any other non-infectious pulmonary abnormalities?
   yes [ ] no [ ]

350 Specify other pulmonary abnormality: ________________________________

351 Did the recipient receive endotracheal intubation or mechanical ventilation post-HSCT?
   yes [ ] no [ ]

Liver Function

352 Did the recipient develop non-infectious liver toxicity (excluding GVHD) after the start of preparative regimen to date of last contact (question 1)?
   yes [ ] no [ ]

353 Date of diagnosis: ________-______-______

   Etiology:

354 cirrhosis
   yes [ ] no [ ]

355 veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS)
   yes [ ] no [ ]

356 Did the recipient receive treatment for VOD?
   yes [ ] no [ ]

357 Specify: ________________________________

358 Did VOD resolve by day 100?
   yes [ ] no [ ]

359 Maximum bilirubin in first 100 days: ________________________________

360 Other
   yes [ ] no [ ]

361 Specify other etiology: ________________________________

362 Unknown
   yes [ ] no [ ]

   Specify diagnosis of liver toxicity by clinical signs and symptoms/evaluation:

363 ascites
   yes [ ] no [ ]

364 autopsy
   yes [ ] no [ ]
365  bilirubin > 2.0 mg
   yes  no

366  biopsy
   yes  no

367  elevated hepatic venous pressure gradient
   yes  no

368  elevated liver enzymes (e.g., alkaline phosphatase, ALT, AST, LDH, GGT)
   yes  no

369  hepatomegaly
   yes  no

370  right upper quadrant pain or tenderness
   yes  no

371  ultrasonography / doppler (abnormal portal vein flow)
   yes  no

372  weight gain > 5%
   yes  no

373  Other
   yes  no

374  Specify other evaluation: __________________________

Other Organ Impairment/Disorder

375  Has the recipient developed any other clinically significant organ impairment or disorder after the start of preparative regimen to date of last contact (question 1)?
   yes  no

Specify impairment/disorder:

376  avascular necrosis
   yes  no

377  Date of diagnosis: __ __ __ __ - __ __- __ __

378  cataracts
   yes  no

379  Date of diagnosis: __ __ __ __ - __ __- __ __

380  congestive heart failure (EF < 40%)
   yes  no

381  Date of diagnosis: __ __ __ __ - __ __- __ __

382  diabetes / hyperglycemia
   yes  no

383  Date of diagnosis: __ __ __ __ - __ __- __ __
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>384</td>
<td>gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)</td>
</tr>
<tr>
<td>385</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>386</td>
<td>growth hormone deficiency / growth disturbance</td>
</tr>
<tr>
<td>387</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>388</td>
<td>hemorrhagic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transfusions, urology consult)</td>
</tr>
<tr>
<td>389</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>390</td>
<td>hypothyroidism</td>
</tr>
<tr>
<td>391</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>392</td>
<td>myocardial infarction</td>
</tr>
<tr>
<td>393</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>394</td>
<td>pancreatitis</td>
</tr>
<tr>
<td>395</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>396</td>
<td>post-transplant microangiopathy-thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS), or similar syndrome</td>
</tr>
<tr>
<td>397</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>398</td>
<td>Did the recipient receive plasmapheresis?</td>
</tr>
<tr>
<td>399</td>
<td>renal failure severe enough to warrant dialysis</td>
</tr>
<tr>
<td>400</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>401</td>
<td>Did the recipient receive dialysis?</td>
</tr>
<tr>
<td>402</td>
<td>stroke / seizure</td>
</tr>
<tr>
<td>403</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>404</td>
<td>Other impairment or disorder</td>
</tr>
<tr>
<td>405</td>
<td>Date of diagnosis: __ __ __ __ - __ __ - __ __</td>
</tr>
</tbody>
</table>
| 406  | Specify other impairment / disorder: ___________________________________________________________________________________________________________________________________________________________
New Malignancy

407 Did a new malignancy, lymphoproliferative or myeloproliferative disorder appear that is different from the disease for which the HSCT was performed?

- yes
- no

408 For all new malignancies except for "other skin malignancy (basal cell, squamous)," was testing performed to determine the cell of origin?

- Yes
- No

the only new malignancy in this reporting period was "other skin malignancy (basal cell, squamous)"

409 Specify the cell origin of the new malignancy:

- recipient (host)
- donor
- origin unknown

410 Is a copy of the cell origin evaluation (VNTR, cytogenetics, FISH) attached?

- yes
- no

Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 410 on the report.

Specify which new disease(s) occurred:

411 Acute myeloid leukemia (AML / ANLL)

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

412 Other leukemia, including ALL

- yes
- no

Date of diagnosis: __ __ __ __ - __ __- __ __

413 Specify other leukemia: ______________________

414 Breast cancer

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

415 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

416 Clonal cytogenetic abnormality without leukemia or MDS

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

417 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

418 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)

- yes
- no

Date of diagnosis __ __ __ __ - __ __- __ __

419 Date of diagnosis __ __ __ __ - __ __- __ __

420 Date of diagnosis __ __ __ __ - __ __- __ __

421 Date of diagnosis __ __ __ __ - __ __- __ __

422 Date of diagnosis __ __ __ __ - __ __- __ __

423 Date of diagnosis __ __ __ __ - __ __- __ __

424 Date of diagnosis __ __ __ __ - __ __- __ __

425 Date of diagnosis __ __ __ __ - __ __- __ __
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>426 Hodgkin disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>427 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>428 Lung cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>429 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>430 Lymphoma or lymphoproliferative disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>431 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>432 Is the tumor EBV positive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>433 Melanoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>434 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>435 Other skin malignancy (basal cell, squamous)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>436 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>437 Specify other skin malignancy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438 Myelodysplasia (MDS) / myeloproliferative (MPS) disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>439 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>440 Oropharyngeal cancer (tongue, buccal mucosa)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>441 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>442 Sarcoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>443 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>444 Thyroid cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>445 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>446 Other new malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>447 Date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>448 Specify other new malignancy:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Form 2100 R3.0: 100 Days Post-HSCT Data**

**Center:**

**CRID:**

---

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>449 Is a pathology / autopsy report or other documentation attached?</td>
<td>yes, no</td>
</tr>
<tr>
<td>450 Was the recipient discharged from the hospital after HSCT?</td>
<td>Yes, No, Not applicable, therapy and HSC infusion given as outpatient</td>
</tr>
<tr>
<td>451 Date first discharged from hospital post-HSCT:</td>
<td>__ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>452 Total number of inpatient days (day 0 to day 100) in first 100 days post-HSCT</td>
<td></td>
</tr>
<tr>
<td>453 Which scale was used, Karnofsky or Lansky?</td>
<td>Karnofsky, Lansky</td>
</tr>
<tr>
<td>454 Date of subsequent HSCT:</td>
<td>__ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>455 Was the subsequent HSCT performed at a different institution?</td>
<td>yes, no</td>
</tr>
<tr>
<td>456 Specify the institution that performed the subsequent HSCT:</td>
<td>Name: ____________________________</td>
</tr>
<tr>
<td>City: ____________________________ State / Country: ____________________________</td>
<td></td>
</tr>
<tr>
<td>457 What was the indication for subsequent HSCT?</td>
<td></td>
</tr>
<tr>
<td>Subsequent autologous HSCTs performed for engraftment reasons (options 1–3) do not require separate report forms to be completed. All other subsequent HSCTs will require a separate follow-up report form completed for each infusion.</td>
<td></td>
</tr>
<tr>
<td>458 Specify other indication:</td>
<td></td>
</tr>
<tr>
<td>459 Source of HSCs:</td>
<td>Allogeneic, related, Allogeneic, unrelated, Autologous</td>
</tr>
<tr>
<td>460 Was the same donor used?</td>
<td>yes, no</td>
</tr>
</tbody>
</table>

---

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.
**Donor Cellular Infusion (DCI) Information**

**Questions: 462 - 560**

**DCI (1)**

<table>
<thead>
<tr>
<th>Questions: 462 - 560</th>
</tr>
</thead>
</table>

462  Date the first DCI was given: __ __ __ - __ __ __

463  Specify the number of cell infusions given within 10 weeks of the first DCI: ____________________________

464  Was the DCI infusion performed at a different institution?

- yes
- no

Specify the institution that performed the DCI:

465  Name: ____________________________

City: ____________________________  State / Country: ____________________________

466  Indication for DCI:

- planned as part of initial HSCT protocol
- treatment for relapsed, persistent or progressive disease
- treatment for B cell lympho-proliferative disorder (PTLD, EBV lymphoma)
- treatment for GVHD
- viral infection
- stable, mixed chimerism
- loss of / decreased donor T-cell chimerism
- Other
Specify the method(s) of disease detection below. For each method used, if the result was positive report the first date the disease was detected; if the result was negative report the last date the method was used prior to DCI (question 462).

467 Molecular
   | Positive | Negative | not done / unknown |
   |         |         |                  |

468 Date: __ __ __ __ - __ __ - __ __

469 Cytogenetic
   | Positive | Negative | not done / unknown |
   |         |         |                  |

470 Date: __ __ __ __ - __ __ - __ __

471 clinical evidence / hematologic
   | Positive | Negative | not done / unknown |
   |         |         |                  |

472 Date: __ __ __ __ - __ __ - __ __

473 Was chemotherapy used to attempt to induce disease response prior to the first DCI?
   | yes | no |

474 Date of administration of final chemotherapy dose: __ __ __ __ - __ __ - __ __

475 Specify viral organism code: ____________________________

476 Date documented: __ __ __ __ - __ __ - __ __ (document chimerism testing beginning at question 81 or question 91)

477 Specify other indication: ____________________________

478 What was the recipient's disease status immediately prior to the first DCI?
   | first complete remission post-HSCT (no hematologic evidence of disease)
   | therapy-induced complete remission after persistent disease or relapse post-HSCT
   | Relapse or progression
   | Persistent disease
   | not evaluated post-HSCT

479 Date disease status was established prior to the first DCI: __ __ __ __ - __ __ - __ __

If the recipient is 16 years or older, complete the Karnofsky Scale. If the recipient is younger than 16 years of age, complete the Lansky Scale.

480 Specify the functional status of the recipient immediately prior to the first DCI: ____________________________

Specify DCI source:

481 collected at the time of PBSC mobilization and collection
   | yes | no |

482 negative fraction of CD34 selected PBSC
   | yes | no |

483 negative fraction of CD34 selected bone marrow
   | yes | no |

484 apheresis at a different time than collection of PBSC used for allogeneic HSCT
   | yes | no |

485 Date of Apheresis: __ __ __ __ - __ __ - __ __
isolated from a unit(s) of whole blood

Were the donor cells collected by leukapheresis?

Date of first leukapheresis:

Date of last leukapheresis:

Number of leukaphereses:

Did the donor receive treatment to enhance cell collection prior to donation?

Specify treatment(s) given:

For each DCI given, report the total number of cells infused. If the cells were cryopreserved, report the totals after processing, but before cryopreservation.

CD3+ cells not tested

CD4+ cells not tested

CD8+ cells not tested

CD34+ cells not tested

NK cells not tested

Nucleated cells not tested
<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nucleated cells:</td>
<td>x10 Specify exponent:</td>
<td></td>
</tr>
<tr>
<td>Mesenchymal cells:</td>
<td>x10 Specify exponent:</td>
<td></td>
</tr>
<tr>
<td>Were dendritic cells infused?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Were fibroblasts infused?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Were any other cell types infused?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Specify other cell type(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were the cells cryopreserved prior to infusion?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Specify portion cryopreserved:</td>
<td>all cells</td>
<td>portion of cells</td>
</tr>
<tr>
<td>Were the cells manipulated prior to infusion?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Specify portion manipulated:</td>
<td>all cells</td>
<td>portion of cells</td>
</tr>
<tr>
<td>Specify all methods used to manipulate the cells:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABO incompatibility</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Buffo coat preparation</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Cell separator (i.e., COBE Spectra)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Density gradient separation (i.e., Ficoll)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Plasma removal</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Sedimentation (i.e., hetastarch)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Other</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
Specify other method: ____________________________

523  dextran-albumin wash
   yes  no

524  ex-vivo expansion
   yes  no

525  genetic manipulation (gene transfer / transduction)
   yes  no

526  volume reduction
   yes  no

527  CD34+ selection
   yes  no

528  Specify manufacturer:
   ClinimACS / CliniMax  Isolex  other manufacturer

529  Specify other manufacturer: ____________________________

530  T-cell depletion
   yes  no

   Specify method:

531  Antibody affinity column
   yes - Report antibodies used for T-cell depletion at question 543.
   no

532  Antibody coated plates
   yes - Report antibodies used for T-cell depletion at question 543.
   no

533  Antibody coated plates and soybean lectin
   yes - Report antibodies used for T-cell depletion at question 543.
   no

534  Antibody + complement
   yes - Report antibodies used for T-cell depletion at question 543.
   no

535  Antibody + toxin
   yes - Report antibodies used for T-cell depletion at question 543.
   no
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
</table>
| 536 | Immunomagnetic beads  
|  | yes -Report antibodies used for T-cell depletion at question 543.  
|  | no |
| 537 | Elutriation  
|  | yes  
|  | no |
| 538 | CD34 affinity column plus sheep red blood cell rosetting  
|  | yes  
|  | no |
| 539 | Other  
|  | yes  
|  | no |
| 540 | Specify other method: __________________________ |
| 541 | Other cell manipulation  
|  | yes  
|  | no |
| 542 | Specify other cell manipulation: __________________________ |
| 543 | Were antibodies used during graft manipulation?  
|  | yes  
|  | no |
| 544 | Anti CD2  
|  | yes  
|  | no |
| 545 | Anti CD4  
|  | yes  
|  | no |
| 546 | Anti CD5  
|  | yes  
|  | no |
| 547 | Anti CD6  
|  | yes  
|  | no |
| 548 | Anti CD7  
|  | yes  
|  | no |
| 549 | Anti CD8  
|  | yes  
|  | no |
| 550 | Anti CD34  
|  | yes  
|  | no |
| 551 | Anti TCR alpha / beta (T10-B9)  
|  | yes  
|  | no |
| 552 | OKT-3  
|  | yes  
<p>|  | no |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>553 Other CD3</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>554 Specify other CD3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>555 Anti CD52</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Specified antibodies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>556 campath-NOS</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>557 campath-1G</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>558 campath-1H</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>559 Other antibody</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>560 Specify other antibody:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First Name: __________________________ Last Name: __________________________
Phone number: __________________________ Fax number: __________________________
E-mail address: __________________________