Sequence Number:	ERROR C		FION I	FORM	Visit: ☐ 100 day
Sequence Number.		CIBIVITA	Recipient ib.		☐ 6 month
Today's Date:	Infusion Da	ate:	CIBM	TR Center Number:	Initials:
Month Day	2 0 Month	Day Year			
	CIBMTR TER FOR INTERNATIONAL BLOOD RROW TRANSPLANT RESEARCH	CIBMTR Center Number CIBMTR Recipient ID:		To and to LICIDALT?	
	e Deficiencies SCT Data	1 ☐ yes — → US 2 ☐ no		Joined to OSIDNET!	
	Registry Use Only	Today's Date: Month	Day 2 0) Year	
Sequence Number:		Date of HSCT for which being completed: ☐ HSCT type: ☐ autolo		eic, 🛘 allogeneic, 🗘 sy	/ear rngeneic titical twin)
Date Received:		Product type: ☐ marro		☐ cord blood ☐ other proc specify: ☐ ☐ 2 years ☐ > 2 years, specify:	duct,
Questions reference Laborato Report the result of the res	npleted in conjunction with a Form 2° T Data, or Form 2300 – Yearly Folic Id reflect the date of last contact as resist followed by the symbol indicated in the forms instruction manual. The symbol forms instruction manual in the forms instruction manual. The symbol forms in the symbol form	everup for Greater Than eported in the post-HSCT te additional information te last report. For question estion 48, or in the Form 2	Two Years Post- data collection for n necessary to co	HSCT Data. Information rm, or immediately prior omplete the question is preport CBC results in the	reported to death.
1. Date of		onth Day Year Specify units:			
2. WBC:		1 \square x 10 ⁹ /L (x 10 ³ /mm ³) 2 \square x 10 ⁶ /L	☐ not tested		
3. Lympho	ocytes: %		☐ not tested		
4. Eosino	phils: %		☐ not tested		
5 Polymo	orphonuclear leukocytes (PMN):	%	☐ not tested		
6. Hemog	llobin:		□ not tested	☐ transfused RBC < 30 from date of most curren	•
7. Platele	to.	1 □ x 10 ⁹ /L (x 10 ³ /mm ³) 2 □ x 10 ⁶ /L	☐ not tested	☐ transfused platelets < from date of most currer	•

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

year

FRF	OR CORE	RECTION FO	ORM Visit:
Sequence Number:		CIBMTR Recipient ID:	☐ 100 day
Today's Date:	Infusion Date:	CIBMTR (Center Number: Initials:
20		20	
Month Day Year	Month Day	Year	
CIBMTR Center Number:		CIBMTR Recipient ID:	
Immunoglobulin Analysis			
For questions 8–13, also report of the second secon	rt immunoglobulins in the Form 2 wo Years Post-HSCT Data begin	Days Post-HSCT Data beginning at que stion 32.	
Value:	Specify units:	Date tested: Month Day Year	
8. IgG:	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	9.	□ not tested
10. lgM:	1	11.	□ not tested
12. lgA:	1 mg/dL 2 g/dL 3 g/L	13.	□ not tested
14. lgE: IU/n	_	15.	☐ not tested
	supplemental intravenous immun	oglobulins (IVIG) since the date of the la	ast report?
1 □ yes	17. Was therapy ongoing within 1 □ yes 2 □ no	one month of immunoglobulin testing?	
For questions 19 and 21–25,	to Two Years Post-HSCT Data be	rm 2100 – 100 Days Post-HSCT Data beginning at question 42.	peginning at question 71, or in
2 2 110	5	Month Day	Year
	20. Absolute lymphocyte count: % of total lym		cells / µL (cells / mm³) Specify units:
	21. CD3 (T cells):	- or -	1 □ x 10 ⁹ /L □ not (x 10 ³ /mm ³) tested
	22. CD4 (T helper cells):	- or -	2 □ x 10 ⁶ /L 1 □ x 10 ⁹ /L □ not (x 10 ³ /mm ³) tested
	23. CD8 (cytotoxic T cells):	- or -	2 □ x 10 ⁶ /L 1 □ x 10 ⁹ /L □ not (x 10 ³ /mm ³) tested
	24. CD20 (B lymphocyte cells): ➤	- or -	2 \(\times \) \(10^{9}/L \) \(\times \) \(10^{3}/mm^{3} \) \(\text{tested} \)
	25. CD56 (natural killer (NK) cells): →	- or -	2 □ x 10 ⁶ /L 1 □ x 10 ⁹ /L □ not (x 10 ³ /mm ³) tested
CIBMTR Form 2131 revision 2 (p Copyright © 2009 National Marro The Medical College of Wisconsi Internal use: Document number F00535	w Donor Program and	ily 2007	2 □ x 10 ⁶ /L

			D C	ND	RECTION FORM	/isit:
		EKKU	A C	JA		□ 100 day
Sequence I	Number:				CIBMTR Recipient ID:	☐ 6 month
Today's Da	te:		Infusion Da	ate:	CIBMTR Center Number: I	nitials:
					20	
	2	0		L_	20	
Month	Day	Year	Month	Day	Year	
	CIBMTR Center	Number:			CIBMTR Recipient ID:	
			0/	of total	mphocytes: Value: Specify units:	
			CD4+ / CD45RA	+		¬ not
		(naive T cells): -	-> _	-0 -	⊐ not ∣ ested
		27 (CD4+ / CD45RC)+	2 □ x 10 ⁶ /L	
			memory T cells)		-0 -	□ not
					(x 10 ³ /mm ³) t	ested
	Antibody Resp					
	Specify the mos	t recent antibody res	sponses measu	red since	he date of the last report.	
	28. Date antibo	ody responses were	assessed:		20	
	Absent Low	Normal Not tested	М	onth	lay Year	
	1		29. Bacteriopha	ge phi X	74 or other neoantigen	
	1 🛮 2 🗖		30. Diptheria		•	
	1 0 2 0		31. Isohemaggl			
	1		32. Isohemaggl		B 3 or pneumococcal vaccine	
	1 0 2 0		34. Tetanus	ugateu i	of pheumococcal vaccine	
		ted pneumococcal p			1	
	oo. ooo.,juga.		pes producing a prof	tective leve	/ Total serotypes tested from vaccine	
	26 Conjugated	I pneumococcal poly			1	
	30. Conjugated			tective leve	/ Total serotypes tested from vaccine	
			bes producing a pro-	lective leve	/ Total servições tested from vaccine	
	Lymphocyte Fu		£		handata of the last organi	
				rea since	he date of the last report.	
	37. Date lymph	ocyte function was			20	
	Absent	Low	M Normal	onth Not	ay Year	
		(10-30% of control) (3		tested		
	1 🗆	2 🗖	3 🗆	4 🔲	38. Anti-CD3	
	1 🗆	2 🗆	3 🗆	4 🗆	89. Candida antigen	
	1 🗆 1 🗖	2 🗆 2 🗖	3 🗆 3 🗖	4 □ 4 □	10. Concavalin A (ConA) 11. Phytohemagglutinin (PHA)	
	1 🗆	2 🗆	3 🗆	4 🗆 4 🗖	12. Pokeweed mitogen (PWM)	
	1 🗆	2 🗖	3 🗆	4 🗆	43. Tetanus antigen	

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Sequence Number:	RROR CO	R			ION ecipient ID:	F	ORI	M	Visit: □ 100 day □ 6 month
Today's Date:	Infusion Date	:			CIB	MTF	R Center N	— umber	: Initials:
Month Day 2 0	ear Month D	Day	2 0 Ye	ar					
CIBMTR Center Nur	nber:		CIBMT	R Red	cipient ID:				
Clinical Feature	es Assessed Post-HSCT								
identified, use the Conganism once, ever Also report infections	d Post-HSCT of all clinically significant infectior odes for Commonly Reported Orga if it was identified at the same site in the Form 2100 – 100 Days Post T Data beginning at question 319.	inisms e in su st-HS	s on the follow ubsequent info	ing pa	age to report tl s.	ne org	ganism preser	nt. Only i	report an
Copy this chart to re	eport more than three different infe	ctions	identified at a	ny or	e site; check h	ere C	if additional	pages a	re attached.
Site of infection?			First organism		Second organisi	n	Third organism	Specify	other organism
44. 1 ☐ yes 2 ☐ ne	Hepatitis —	4 5.		46.		47.		48	
	49. If hepatitis was present, was 1 □ yes 2 □ no	it a p	rominent feat	ure of	ID?				
50. 1 ☐ yes 2 ☐ ne	Meningitis / encephalitis	- 51.		52.		53.		54	
	55. If meningitis / encephalitis w 1 □ yes 2 □ no	as pre	esent, was it a	prom	inent feature o	of ID?			
56. 1 □ yes 2 □ n	p Pneumonia ———	5 7.		58.		59.		60	
	61. If pneumonia was present, w 1 □ yes 2 □ no	as it a	a prominent fe	eature	of ID?				
62. 1 ☐ yes 2 ☐ ne	Severe or protracted diarrhea	- 63.		64.		65.		66	
	67. If diarrhea was present, was 1 □ yes 2 □ no	it a p	rominent feat	ure of	ID?				
68. 1 □ yes 2 □ ne	Systemic infection ————	- 69.		70.		71.		72	
	73. If systemic infection was pre 1 ☐ yes 2 ☐ no	sent,	was it a prom	inent i	feature of ID?				
74. 1 ☐ yes 2 ☐ n	Other infection ————	> 75.		76.		77.		78	
	79. Specify other infection site:								

1 □ yes 2 □ no

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

Sequence Number:	OR CORRECTION CIBMTR Recip		Visit: ☐ 100 day ☐ 6 month ☐ year
Today's Date: Day Pear Pear	Infusion Date: Month Day Year	CIBMTR Center Number:	Initials:
CIBMTR Center Number:	CIBMTR Recipie	nt ID:	

Codes for Commonly Reported Organisms 149 Leuconostoc (all species) **Bacterial Infections** 167 Streptococcus (all species 302 Varicella (herpes zoster, 104 Listeria except Enterococcus) chicken pox) 121 Acinetobacter 150 Methylobacterium Streptococcus pneumoniae 303 Cytomegalovirus (CMV) 122 Actinomyces 151 Micrococcus, NOS 168 Treponema (syphilis) 304 Adenovirus 123 Bacillus 112 Mycobacterium avium-169 Vibrio (all species) 305 Enterovirus (coxsackie, 124 Bacteroides (gracillis, intracellulare (MAC, MAI) Multiple bacteria at a single echo, polio) uniformis, vulgaris, other Mycobacterium species Hepatitis A (HAV) site, specify bacterial codes species) (cheloneae, fortuitum, Other bacteria, specify ‡ 307 Hepatitis B (HBV, Bordetella pertussis haemophilum, kansasii, Suspected atypical Australian antigen) † (whooping cough) 308 Hepatitis C (HCV) † mucogenicum bacterial infection 126 Borrelia (Lyme disease) 110 Mycobacterium 502 Suspected bacterial 309 HIV-1 (HTLV-III) ¤ 127 Branhamella or Moraxella tuberculosis (tuberculosis, infection 310 Influenza, NOS catarrhalis (other species) Koch bacillus) 323 Influenza A Campylobacter (all **Fungal Infections** 175 Other mycobacterium, 324 Influenza B species) 200 Candida, NOS specify 311 Measles (rubeola) 129 Capnocytophaga 201 Candida albicans 176 Mycobacterium, NOS 312 Mumps 171 Chlamydia pneumoniae 206 Candida guillermondi Mycoplasma Progressive multifocal 172 Other chlamydia, specify Candida krusei Neisseria (gonorrhoea, leukoencephalopathy 113 Chlamydia, NOS 207 Candida lusitaniae meningitidis, other species) (PML) 130 Citrobacter (freundii, other 203 Candida parapsilosis 106 Nocardia 314 Respiratory syncytial virus species) 204 Candida tropicalis 153 Pasteurella multocida (RSV) 131 Clostridium (all species 205 Candida (Torulopsis) Propionibacterium (acnes, 315 Rubella (German measles) except difficile) glabrata 316 Parainfluenza avidum, granulosum, other Clostridium difficile 209 Other Candida, specify ‡ species) 317 Human herpesvirus-6 173 Corvnebacterium ieikeium 210 Aspergillus, NOS § 155 Proteus (HHV-6) Corynebacterium (all non-211 Aspergillus flavus § 156 Pseudomonas (all species 318 Epstein-Barr virus (EBV) diptheria species) 212 Aspergillus fumigatus § except cepacia & Polyoma virus (BK virus, 101 Coxiella 213 Aspergillus niger § maltophilia) JC virus) 134 Enterobacter 219 Other Aspergillus, specify ‡ 320 Rotavirus Pseudomonas or 177 Enterococcus, vancomycin Burkholderia cepacia 321 Rhinovirus resistant (VRE) 220 Cryptococcus species 322 Human papilloma virus 158 Pseudomonas or 135 Enterococcus (all species) 230 Fusarium species § Stenotrophomonas or 136 Escherichia (also E. coli) 261 Histoplasmosis Xanthomonas maltophilia 329 Other virus, specify ‡ 137 Flavimonas oryzihabitans 240 Zygomycetes, NOS § 159 Rhodococcus 504 Suspected viral infection 138 Flavobacterium 241 Mucormycosis § 107 Rickettsia 139 Fusobacterium Parasitic Infections 242 Rhizopus § 160 Salmonella (all species) 144 Haemophilus (all species, 250 Yeast, NOS 402 Toxoplasma 161 Serratia marcescens including influenzae) 259 Other fungus, specify ‡ 403 Giardia 162 Shigella 145 Helicobacter pylori 260 Pneumocystis (PCP / PJP) 404 Cryptosporidium 163 Staphylococcus, coagulase 146 Klebsiella 503 Suspected fungal infection 409 Other parasite, specify ‡ negative (not aureus) 147 Lactobacillus (bulgaricus, Suspected parasite 164 Staphylococcus aureus Viral Infections acidophilus, other species) infection 165 Staphylococcus, NOS 102 Legionella 301 Herpes simplex (HSV1, 166 Stomatococcus Other Infections 103 Leptospira HSV2) mucilaginosis 509 No organism identified 148 Leptotrichia buccalis

- [‡] The codes for "other organism, specify" (codes 198, 209, 219, 259, 329 and 409) should rarely be needed; check with your microbiology lab or HSCT physician before using them.
- § For fungal infections marked with a section symbol (codes 210, 211, 212, 213, 219, 230, 240, 241, and 242), also complete a Fungal Infection (FNG) form.
- † For hepatitis infections marked with a dagger symbol (codes 307 and 308), also complete a Hepatitis (HEP) form.
- For HIV infections marked with a currency symbol (code 309), also complete an HIV Infection (HIV) form.
- * Do not report fever in the absence of infection. Report the most specific site of infection.

ERF Sequence Number:	ROR CO	RRECTION CIBMTR Recipient ID:	FORM	Visit: ☐ 100 da
Sequence Number.		CIBIVITA Recipient ib.		□ 6 mont
Today's Date:	Infusion Date:	CIB	MTR Center Number:	Initials:
20		20		
Month Day Year	Month Da			
CIBMTR Center Number:		CIBMTR Recipient ID:		
Clinical Status Post-HSCT				
81. Did the recipient experie 1 □ yes ————	, ,	nical features (since the date of the las	st report)?	
2 □ no	Specify clinical features: Feature present?		If present, is the feature prominent?	
	•	oimmune hemolytic anemia ————	•	
		ure to thrive (weight < 5 th percentile) - ft versus host disease — acute ———		
	•	ft versus host disease — acute —— ft versus host disease — chronic —	•	
	90. 1 ☐ yes 2 ☐ no Gro	wth hormone deficiency ————	→ 91. 1 □ yes 2 □ no	
		wth retardation (height < 5 th percentile uphoproliferative disease		
	•	ombotic thrombocytopenic purpura —		
		o-occlusive disease (VOD) —		
	100. 1 ☐ yes 2 ☐ no Wa	ts ———————er features ————	→ 101. 1 ☐ yes 2 ☐ no	
		. Specify other features:	7 100. 1 Ll yes 2 Ll 110	
105. Did the recipient receive 1 □ yes 2 □ no	parenteral nutrition (since	he date of the last report)?		
106. Did the recipient receive 1 ☐ yes 2 ☐ no	mechanical ventilation (sin	ce the date of the last report)?		
Post-HSCT Treatment		-		
107. Was treatment given (sir	Complete the table below	•		
•	Continue with question 1			
Also report immunosuppre 2000 — Recipient Baseline	essive medications given	to prevent or treat GVHD in the cor Days Post-HSCT Data, Form 2200 — reater Than Two Years Post-HSCT D	- Six Months to Two Years I	
,		be considered as "Prophylactic Dru		
			ag Stopped.	
Prophylactic Drug Given? 108. Antifungal drug(s)	Prophylactic Drug Stopped	I? Date Stopped Month Day Year		
	109. 1 ☐ yes — ➤ 1	10. 20	☐ date estimated☐ date unknown	
2 ☐ no	2 □ no		Late ulikilowil	
111. Antiviral drug(s) 1 □ ves ————	112. 1 □ yes — → 1	13. 20	☐ date estimated	
2 □ no	2 □ no		□ date unknown	
114. Co-trimoxazole (Bactrim 1 ☐ yes ———————————————————————————————————	, Septra) 115. 1 ☐ yes ———— 1 2 ☐ no	16. 20	☐ date estimated☐ date unknown	

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	ROR CORRECTION FORM .	/isit: □ 100 day
Sequence Number:	CIBMTR Recipient ID:	☐ 6 month
Today's Date:	Infusion Date: CIBMTR Center Number: In	nitials:
Month Day Year	Month Day Year	
CIBMTR Center Number:	CIBMTR Recipient ID:	
Therapy paused for < 1 w	eek should <i>not</i> be considered as "Therapy Stopped."	
Therapy Given?	Therapy Stopped? Date Stopped	
1 □ yes	ATG, ATGAM, Thymoglobulin) 118. 1 □ yes 119. □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	
2 🗖 no	121. 1 ☐ yes — → 122. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
123. Corticosteroids, topical 1 ☐ yes → 2 ☐ no 126. Cyclophosphamide (CT.	124. 1 ☐ yes → 125. ☐ ☐ ☐ ☐ date estimated ☐ date unknown	
1 ☐ yes 2 ☐ no	127. 1 ☐ yes	
2 ☐ no	130. 1 ☐ yes — → 131. ☐ ☐ ☐ date estimated ☐ date unknown	
132. In vivo monoclonal antib	oody	
2 □ no	Specify monoclonal antibody: Therapy Given? Therapy Stopped? Date Stopped	
	133. Alemtuzumab (Campath) Month Day Year	
	1 ☐ yes → 134. 1 ☐ yes → 135. ☐ ☐ ☐ date estir ☐ date unkr	
	136. Daclizumab (anti-CD25, Zenapax) 1 □ yes → 137. 1 □ yes → 138. □ □ □ date estir 2 □ no	
	139. Etanercept (Enbrel) 1 □ yes → 140. 1 □ yes → 141. 2 □ no 2 □ no □ date estir □ date unkr	
	142. Infliximab (anti-TNF-α, Remicade) 1 □ yes → 143. 1 □ yes → 144. 2 □ no 2 □ no □ date estir □ date unkr	
	145. Muromonab (anti-CD3, OKT3) 1 □ yes → 146. 1 □ yes → 147. □ date estir 2 □ no 2 □ no □ date unkr	
	148. Rituximab (anti-CD20, Rituxan, MabThera) 1 □ yes → 149. 1 □ yes → 150. □ □ date estir 2 □ no 2 □ no □ date unkr	
	151. Other monoclonal antibody 1 □ yes → 152. 1 □ yes → 153. □ □ □ date estir 2 □ no 2 □ no □ date unkr	

154. Specify other monoclonal antibody: _

ERROR COR	RECTION FO	ORM	Visit: ☐ 100 day
Sequence Number.	CIDINTIX Recipient ID.		☐ 6 month
Today's Date: Infusion Date:	CIBMTR	Center Number:	Initials:
	20		
Month Day Year Month Day	Year		
CIBMTR Center Number:	CIBMTR Recipient ID:		
Therapy Given? Therapy Stopped?	Date Stopped		
155. Lenalidomide (Revlimid)	Month Day Year	☐ date estimated	
1 ☐ yes — → 156. 1 ☐ yes — → 157. 2 ☐ no 2 ☐ no		☐ date estimated ☐ date unknown	
158. Mycophenolate mofetil (MMF, Cellcept)			
1 □ yes — → 159. 1 □ yes — → 160.	20	☐ date estimated ☐ date unknown	
2 \(\text{no} \) 161 Photophorosic / outrocorporal photothoropy (FCR)			
161. Photopheresis / extracorporeal phototherapy (ECP) 1 □ yes → 162. 1 □ yes → 163.	20	☐ date estimated	
2 □ no 2 □ no		☐ date unknown	
164. Sirolimus (Rapamune) 1 □ yes → 165. 1 □ yes → 166.	20	☐ date estimated	
2 \(\text{no} \) no \(2 \) no		☐ date unknown	
167. Tacrolimus (FK506, Prograf)		☐ date estimated	
1 ☐ yes — → 168. 1 ☐ yes — → 169. 2 ☐ no 2 ☐ no		☐ date unknown	
170. Thalidomide (Thalomid)			
1 ☐ yes — → 171. 1 ☐ yes — → 172.		☐ date estimated☐ date unknown	
2 ☐ no 2 ☐ no 173. Other immunosuppressive drug			
1 □ yes — → 174. 1 □ yes — → 175. 2 □ no 2 □ no	20	☐ date estimated ☐ date unknown	
176. Specify other immunosupp	pressive drug:		
177. Did the recipient receive any other significant treatment	(s) for ID (since the date of the last report	1)?	
1 ☐ yes ———————————————————————————————————):		
2.2.10			
Status of Hematologic Engraftment			
This section refers to quantitative analyses utilizing dis separation or sorting into T, B, or lymphoid vs. myeloid indicate only donor type hematopoiesis, mark T-cell, B- Also report chimerism in the Form 2100 – 100 Days Pos to Two Years Post-HSCT Data beginning at question 48.	populations to perform this determina cell, and myeloid as "predominantly o st-HSCT Data beginning at question 77	ation. If RFLP analyse r completely donor."	s
179. What is the current status of T-cell engraftment? 1 ☐ predominantly or completely donor (≥ 80% donor cf 2 ☐ mixed chimerism (5–80% donor) 3 ☐ only host T-cells detected (< 5% donor) 4 ☐ unknown			
180. Most recent date T-cell engraftment was assessed:	Month Day Year	☐ date unknown	
181. What is the current status of B-cell engraftment? 1 □ predominantly or completely donor (≥ 80% donor ct 2 □ mixed chimerism (5–80% donor) 3 □ only host B-cells detected (< 5% donor) 4 □ unknown	nimerism)		
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ERROR CORRECTION FORM Sequence Number: CIBMTR Recipient ID: Today's Date: Infusion Date: CIBMTR Center Number:	Visit: ☐ 100 day ☐ 6 month ☐ ☐ ☐ year Initials:
Month Day Year Month Day Year	
CIBMTR Center Number: CIBMTR Recipient ID:	
182. Most recent date B-cell engraftment was assessed: 2 0 □ date unknown	
Month Day Year 183. What is the current status of myeloid engraftment? 1 □ predominantly or completely donor (≥ 80% donor chimerism) 2 □ mixed chimerism (5–80% donor) 3 □ only host myeloid cells detected (< 5% donor) 4 □ unknown	
184. Most recent date myeloid engraftment was assessed: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
185. Signed:	

Fax number: (_____
E-mail address: ___

Phone number: (_____) _____