ERROR CORRECTION FORM

Sequence Number:

CIBMTR Recipient ID:

Visit:
☐ 100 day
☐ 6 month
☐ ___ year

Today's Date: Month / Day / 20__ Year

Infusion Date: Month / Day / 20__ Year

CIBMTR Center Number:

Initials:

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Chediak-Higashi Syndrome Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: Month / Day / 20__ Year

Date of HSCT for which this form is being completed: 🕮 Month / Day / Year

HSCT type: ☐ autologous ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: ☐ marrow ☐ PBSC ☐ cord blood ☐ other product, specify: _____

Visit: ☐ 100 day ☐ 6 month ☐ 1 year ☐ 2 years ☐ > 2 years, specify:

To be completed in conjunction with a Form 2100 – 100 Days Post-HSCT Data, Form 2200 – Six Months to Two Years Post-HSCT Data, or Form 2300 – Yearly Follow-Up for Greater Than Two Years Post-HSCT Data. Information reported here should reflect the date of last contact as reported in the post-HSCT data collection form, or immediately prior to death.

1. What is the date the recipient's current status was evaluated? Month / Day / 20__ Year

2. What is the status of any clinical features of Chediak-Higashi Syndrome at the date of last contact for this report?
   1 ☐ absent
   2 ☐ persistent →
   3 ☐ recurrent →

   3. Date of recurrence:
      1 ☐ known →
      2 ☐ unknown

      4. Specify: Month / Day / Year ☐ date previously reported

   Specify clinical feature(s) present:

   5. 1 ☐ present 2 ☐ absent 3 ☐ unknown Anemia (Hb < 10g/dL)
   6. 1 ☐ present 2 ☐ absent 3 ☐ unknown Bleeding diathesis
   7. 1 ☐ present 2 ☐ absent 3 ☐ unknown Hepatomegaly
   8. 1 ☐ present 2 ☐ absent 3 ☐ unknown Leukocyte granules
   9. 1 ☐ present 2 ☐ absent 3 ☐ unknown Neutropenia (ANC < 1 x 10^9/L)
   10. 1 ☐ present 2 ☐ absent 3 ☐ unknown Recurrent infections
   11. 1 ☐ present 2 ☐ absent 3 ☐ unknown Splenomegaly
   12. 1 ☐ present 2 ☐ absent 3 ☐ unknown Thrombocytopenia (< 100 x 10^9/L)
   13. 1 ☐ present 2 ☐ absent 3 ☐ unknown Other → 14. Specify: _____

15. What was the status of any neurologic symptoms of Chediak-Higashi Syndrome since the date of the last report?
   1 ☐ absent
   2 ☐ present →
   3 ☐ unknown

   16. Were neurologic symptoms present prior to the HSCT?
      1 ☐ yes →
      2 ☐ no (symptoms are newly developed)
      3 ☐ unknown

      17. What is the current status of neurologic dysfunction compared to prior to the HSCT?
         1 ☐ improved
         2 ☐ unchanged
         3 ☐ worse
         4 ☐ unknown

CIBMTR Form 2132 (CHS) v1.0 (1–2) July 2007

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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

Sequence Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CIBMTR Recipient ID: ☐☐☐☐☐☐☐☐☐

Visit:
☐ 100 day
☐ 6 month
☐ ☐☐ year

Today's Date: ☐☐ (Month) ☐☐ (Day) 20☐☐ (Year)

Infusion Date: ☐☐ (Month) ☐☐ (Day) 20☐☐ (Year)

CIBMTR Center Number: ☐☐☐☐☐

Initials: ☐☐☐

CIBMTR Center Number: ☐☐☐☐☐

CIBMTR Recipient ID: ☐☐☐☐☐☐☐☐☐

18. Did the recipient develop features of accelerated phase since the date of the last report?
1 ☐ yes →
2 ☐ no

19. Date of diagnosis: ☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year) ☐ date previously reported

20. Did the recipient have magnetic resonance imaging (MRI) of the brain since the date of the last report?
1 ☐ yes →
2 ☐ no
3 ☐ unknown

21. Specify MRI findings: _____

22. Is a copy of the MRI report attached?
1 ☐ yes
2 ☐ no

Current Assessment of Immunologic Function Post-Transplant

("Absent" is defined as ≤ 10% of normal value; "decreased" is defined as 11–50% of normal value.)

	Absent	Decreased	Normal	Increased	Not tested		Date of test: Month	Day	Year	Date unknown
23. Cytotoxic T-cell activity	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	24.	☐☐	☐☐	☐☐☐☐	☐
25. Granulocyte chemotaxis	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	26.	☐☐	☐☐	☐☐☐☐	☐
27. IgG	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	28.	☐☐	☐☐	☐☐☐☐	☐
29. IgA	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	30.	☐☐	☐☐	☐☐☐☐	☐
31. IgM	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	32.	☐☐	☐☐	☐☐☐☐	☐
33. IgE	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	34.	☐☐	☐☐	☐☐☐☐	☐
35. Natural killer cell activity	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	36.	☐☐	☐☐	☐☐☐☐	☐
37. T-cell numbers / subsets	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	38.	☐☐	☐☐	☐☐☐☐	☐
39. T-cell function	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	40.	☐☐	☐☐	☐☐☐☐	☐

41. Did the recipient receive IVIg infusions within 2 months prior to the above immunoglobulin measurement?
1 ☐ yes
2 ☐ no
3 ☐ unknown

42. Signed: _____
Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____

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