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

X-Linked Lymphoproliferative 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.

Post-HSCT Clinical Status

Specify the recipient's clinical status post-HSCT:

1. 1 ☐ present 2 ☐ absent 3 ☐ unknown Hepatomegaly (> 3 cm below right costal margin)
2. 1 ☐ present 2 ☐ absent 3 ☐ unknown Hypertriglyceridemia (> 200 mg/dL)
3. 1 ☐ present 2 ☐ absent 3 ☐ unknown Hypofibrinogenemia (< 150 mg/dL)
4. 1 ☐ present 2 ☐ absent 3 ☐ unknown Splenomegaly (> 3 cm below left costal margin)

Specify the recipient's cerebrospinal fluid findings post-HSCT:

5. 1 ☐ normal 2 ☐ elevated 3 ☐ not tested Neopterin level
6. 1 ☐ normal 2 ☐ elevated 3 ☐ not tested Protein
7. 1 ☐ ≤ 5 cells/µl 2 ☐ > 5 cells/µl 3 ☐ not tested WBC count

8. What was the recipient's clinical neurologic status post-HSCT?
   1 ☐ normal
   2 ☐ abnormal →

Specify neurologic dysfunction:

	Improvement in Pre-Transplant Abnormalities?	Stable Pre-Transplant Abnormalities?	Deterioration of Pre-Transplant Abnormalities?	Abnormalities Developed Post-transplant?
Seizures	9. 1 ☐ yes 2 ☐ no	10. 1 ☐ yes 2 ☐ no	11. 1 ☐ yes 2 ☐ no	12. 1 ☐ yes 2 ☐ no
Mental retardation	13. 1 ☐ yes 2 ☐ no	14. 1 ☐ yes 2 ☐ no	15. 1 ☐ yes 2 ☐ no	16. 1 ☐ yes 2 ☐ no
Developmental delay	17. 1 ☐ yes 2 ☐ no	18. 1 ☐ yes 2 ☐ no	19. 1 ☐ yes 2 ☐ no	20. 1 ☐ yes 2 ☐ no
Abnormal gait	21. 1 ☐ yes 2 ☐ no	22. 1 ☐ yes 2 ☐ no	23. 1 ☐ yes 2 ☐ no	24. 1 ☐ yes 2 ☐ no
Motor weakness	25. 1 ☐ yes 2 ☐ no	26. 1 ☐ yes 2 ☐ no	27. 1 ☐ yes 2 ☐ no	28. 1 ☐ yes 2 ☐ no
Sensory deficits	29. 1 ☐ yes 2 ☐ no	30. 1 ☐ yes 2 ☐ no	31. 1 ☐ yes 2 ☐ no	32. 1 ☐ yes 2 ☐ no
Other dysfunction	33. Specify other dysfunction: _____			
	34. 1 ☐ yes 2 ☐ no	35. 1 ☐ yes 2 ☐ no	36. 1 ☐ yes 2 ☐ no	37. 1 ☐ yes 2 ☐ no

CIBMTR Form 2134 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).

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Initials:

CIBMTR Center Number: CIBMTR Recipient ID:

38. Was an MRI or CT performed on the central nervous system post-HSCT?
1 ☐ yes → 39. Specify results:
1 ☐ improvement in pre-HSCT abnormalities
2 ☐ stable pre-HSCT abnormalities
3 ☐ worsening of pre-HSCT abnormalities
2 ☐ no

Current Assessment of Immunologic Function Post-Transplant

Specify the clinical status post-HSCT: *(Absent is defined as < 10% normal; decreased is defined as 11–50% normal.)*

40. IgG	1 ☐ absent	2 ☐ decreased	3 ☐ normal	4 ☐ increased	5 ☐ unknown
41. IgA	1 ☐ absent	2 ☐ decreased	3 ☐ normal	4 ☐ increased	5 ☐ unknown
42. IgM	1 ☐ absent	2 ☐ decreased	3 ☐ normal	4 ☐ increased	5 ☐ unknown
43. Natural killer cell activity	1 ☐ absent	2 ☐ decreased	3 ☐ normal	4 ☐ increased	5 ☐ unknown
44. Other immunologic evaluation	1 ☐ absent	2 ☐ decreased	3 ☐ normal	4 ☐ increased	5 ☐ unknown

45. Specify other evaluation: _____

46. Did the recipient receive IVIG within two months prior to the time the immunoglobulin levels were measured?
1 ☐ yes
2 ☐ no
3 ☐ unknown

47. Was the recipient transplanted for lymphoma and XLP?
1 ☐ yes → 48. Specify post-HSCT status of lymphoma:
1 ☐ CR
2 ☐ PR
3 ☐ relapse
4 ☐ unknown
2 ☐ no

49. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

CIBMTR Form 2134 v1.0 (2–2) July 2007
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