

**Congenital Amegakaryocytic
 Thrombocytopenia
 Post-HSCT Data**

Registry Use Only

Sequence
 Number:

Date
 Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: / /
 Month Day Year

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

HSCT type: autologous allogeneic, allogeneic, syngeneic
 unrelated related (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 was the date of the last platelet transfusion since the date of the last report?

<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
Month	Day	Year

2. What was the date of the last red blood cell transfusion since the date of the last report?

<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
Month	Day	Year

3. Was the bone marrow examined since the date of the last report?

- 1 yes
- 2 no

4. Specify the most recent date the bone marrow was
 examined:

<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
Month	Day	Year

5. What was the cellularity of the bone marrow?

- 1 decreased
- 2 normal
- 3 increased

6. What was the megakaryocyte level in the bone marrow?

- 1 decreased
- 2 absent

7. Were myelodysplastic features present?

- 1 yes
- 2 no

8. Specify the level of blasts in the marrow: %

9. Is a copy of the bone marrow report attached?

- 1 yes
- 2 no

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

CIBMTR Center Number:

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10. Was a bone marrow karyotype examination performed since the date of the last report?

- 1 yes
- 2 no
- 3 unknown

11. Were any karyotype abnormalities identified?

- 1 yes
- 2 no

Specify the abnormalities identified:

- 12. 1 yes 2 no -5
- 13. 1 yes 2 no -7
- 14. 1 yes 2 no -17
- 15. 1 yes 2 no -18
- 16. 1 yes 2 no -20
- 17. 1 yes 2 no -X
- 18. 1 yes 2 no -Y
- 19. 1 yes 2 no +4
- 20. 1 yes 2 no +8
- 21. 1 yes 2 no +11
- 22. 1 yes 2 no +13
- 23. 1 yes 2 no +14
- 24. 1 yes 2 no +21
- 25. 1 yes 2 no +22
- 26. 1 yes 2 no del(5q) / 5q-
- 27. 1 yes 2 no del(7q) / 7q-
- 28. 1 yes 2 no del(9q) / 9q-
- 29. 1 yes 2 no del(11q) / 11q-
- 30. 1 yes 2 no del(17q) / 17q-
- 31. 1 yes 2 no del(20q) / 20q-
- 32. 1 yes 2 no inv(3)
- 33. 1 yes 2 no inv(16)
- 34. 1 yes 2 no t(3;3)
- 35. 1 yes 2 no t(6;9)
- 36. 1 yes 2 no t(8;21)
- 37. 1 yes 2 no t(15;17) and variants
- 38. 1 yes 2 no (11q23) balanced abnormality
- 39. 1 yes 2 no 12p any abnormality
- 40. 1 yes 2 no complex (≥ 3 distinct abnormalities)
- 41. 1 yes 2 no other abnormality,
- 42. Specify: _____

43. Is a copy of the cytogenetic report attached?

- 1 yes
- 2 no

44. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____ Fax: (_____) _____

E-mail address: _____