

# 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:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--



## Multiple Sclerosis Post-HSCT Data

Registry Use Only

Sequence Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date Received:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Center Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EBMT Center

Identification Code (CIC):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Today's Date:

Month	Day	20		Year															

Date of HSCT for which this form is being completed:

Month	Day	20		Year															

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

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

Month	Day	Year																	

## Disease Relapses or Progression of Disability Post-HSCT

2. Were there any relapses of multiple sclerosis (MS) since the date of the last report?

yes →  
 no

3. Specify the date of first relapse since the date of the last report:

Month	Day	Year																	

4. Specify the number of relapses since the date of the last report:

																<input type="checkbox"/> number unknown			

5. Did the recipient experience continuous progression of MS since the date of the last report?

yes  
 no  
 unknown

6. Was a MRI scan of the brain performed since the date of the last report?

yes →  
 no  
 unknown

7. Date of most recent MRI:

Month	Day	Year																	

date unknown

8. Was disease relapse / progression detected on the MRI findings?

yes →  
 no

Specify which MRI findings indicated disease relapse / progression:

9.  yes  no  unknown New gadolinium-enhancing lesions

10.  yes  no  unknown Enlarging T2 lesions

11.  yes  no  unknown Radiology report states worsening of MS associated findings



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Sequence Number:

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CIBMTR Recipient ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Visit:

100 day  
 6 month  




 year

Today's Date:

		2	0		
Month	Day	Year			

Infusion Date:

		2	0		
Month	Day	Year			

CIBMTR Center Number:

--	--	--	--	--	--	--	--

Initials:

--

CIBMTR Center Number:

CIBMTR Recipient ID:

- 40. 1  yes 2  no 3  unknown Fingolimod (FTY720)
- 41. 1  yes 2  no 3  unknown Fumarate (oral) (BG00012)
- 42. 1  yes 2  no 3  unknown Glatiramer acetate (Copaxone) [previously copolymer-1]
- 43. 1  yes 2  no 3  unknown Immune globulin (IVIG, Gamimune, Gammagard)
- 44. 1  yes 2  no 3  unknown Interferon beta-1a (Avonex, Rebif)
- 45. 1  yes 2  no 3  unknown Interferon beta-1b (Betaseron)
- 46. 1  yes 2  no 3  unknown Laquinimod
- 47. 1  yes 2  no 3  unknown Methotrexate (MTX, Folex)
- 48. 1  yes 2  no 3  unknown Mitoxantrone (Novantrone)
- 49. 1  yes 2  no 3  unknown Mycophenolate mofetil (MMF, Cellcept)
- 50. 1  yes 2  no 3  unknown Natalizumab (Tysabri, Antegren)
- 51. 1  yes 2  no 3  unknown Rituximab (anti-CD20, Rituxan, MabThera)
- 52. 1  yes 2  no 3  unknown Sirolimus (Rapamune)
- 53. 1  yes 2  no 3  unknown Tacrolimus (FK 506, Prograf)
- 54. 1  yes 2  no 3  unknown Teriflunomide (oral) (HMR1726)
- 55. 1  yes 2  no 3  unknown Blinded randomized trial agent ➤ 56. Specify trial agent: \_\_\_\_\_
- 57. 1  yes 2  no 3  unknown Other treatment \_\_\_\_\_ ➤ 58. Specify other treatment: \_\_\_\_\_

**If the person completing this form is a Neurologist, check here  and continue with the signautre lines below.**

59. Signed: \_\_\_\_\_  
Person completing form

Please print name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

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