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

2. Were there any relapses of multiple sclerosis (MS) since the date of the last report? ☐
   1. yes ☐
   2. 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:
   ☐ number unknown

5. Did the recipient experience continuous progression of MS since the date of the last report?
   1. yes ☐
   2. no ☐
   3. unknown ☐

6. Was a MRI scan of the brain performed since the date of the last report?
   1. yes ☐
   2. no ☐
   3. unknown ☐

7. Date of most recent MRI:
   Month Day Year ☐ date unknown

8. Was disease relapse / progression detected on the MRI findings?
   1. yes ☐
   2. no ☐

Specify which MRI findings indicated disease relapse / progression:

9. ☐ yes 2. no 3. unknown New gadolinium-enhancing lesions
10. 1. yes 2. no 3. unknown Enlarging T2 lesions
11. 1. yes 2. no 3. unknown Radiology report states worsening of MS associated findings

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.
12. Were the Kurtzke Functional Systems Scores (FSS) assessed by a neurologist since the date of the last report?
   1. yes
   2. no
   3. unknown

   Specify the following FSS scores:
   13. Pyramidal:   
   14. Cerebellar:   
   15. Brainstem:   
   16. Sensory:     
   17. Bowel and bladder:   
   18. Visual:      
   19. Cerebral:    
   20. Other function:   

21. Specify other function: ___________________________  

22. Specify the Kurtzke Expanded Disability Status Scale (EDSS):   

23. Specify date of EDSS assessment:   

Post-HSCT Treatment for Multiple Sclerosis

24. Did the recipient receive any treatment for MS since the date of the last report?
   1. yes
   2. no
   3. unknown

   Continue with questions below

   Specify the reason(s) for initiating post-HSCT therapy:

   25. Yes: 2 No:  
   26. Planned therapy per protocol
   27. Disease relapse
   28. Disease progression
   29. Other reason

30. Specify other reason for initiating therapy: ___________________________

31. What was the date the first therapy started?

   Month   Day   Year

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
40. □ yes □ no □ unknown Fingolimod (FTY720)
41. □ yes □ no □ unknown Fumarate (oral) (BG00012)
42. □ yes □ no □ unknown Glatiramer acetate (Copaxone) [previously copolymer-1]
43. □ yes □ no □ unknown Immune globulin (IVIG, Gamimune, Gammagard)
44. □ yes □ no □ unknown Interferon beta-1a (Avonex, Rebif)
45. □ yes □ no □ unknown Interferon beta-1b (Betaseron)
46. □ yes □ no □ unknown Laquinimod
47. □ yes □ no □ unknown Methotrexate (MTX, Folex)
48. □ yes □ no □ unknown Mitoxantrone (Novantrone)
49. □ yes □ no □ unknown Mycophenolate mofetil (MMF, Cellcept)
50. □ yes □ no □ unknown Natalizumab (Tysabri, Antegren)
51. □ yes □ no □ unknown Rituximab (anti-CD20, Rituxan, MabThera)
52. □ yes □ no □ unknown Sirolimus (Rapamune)
53. □ yes □ no □ unknown Tacrolimus (FK 506, Prograf)
54. □ yes □ no □ unknown Teriflunomide (oral) (HMR1726)
55. □ yes □ no □ unknown Blinded randomized trial agent  56. Specify trial agent: 
57. □ yes □ no □ unknown Other treatment  58. Specify other treatment: 

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

59. Signed: _____________________________________________
   Person completing form

   Please print name: _______________________________________

   Phone: (_______) ____________________________

   Fax: (_______) ____________________________

   E-mail address: ________________________________________