Form 2146 R3.0: Fungal Infection Post-Infusion Data

Center: CRID:

Key Fields

Sequence Number: _____________________________
Date Received: __ __ __ __ - __ __- __ __
CIBMTR Center Number: _____________________________
CIBMTR Research ID: _____________________________
Event date: __ __ __ __ - __ __- __ __
Visit: ☐ 100 day ☐ 6 months ☐ 1 year ☐ 2 years ☐ > 2 years,
Specify: _____________________________

Infection Episode

Questions: 1 - 24

Information for this report should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient post-HCT / post-infusion, or abstraction of the recipient’s medical records.

1 Date of infection diagnosis: __ __ __ __ - __ __- __ __

Specify all diagnostic tests performed, which had a positive result, to determine the diagnosis of the fungal infection.

2 Radiographic findings (e.g. x-ray, CT, or MRI)
   ☐ Yes ☐ No

3 Specify imaging sites that supported the diagnosis of fungal infection (check all that apply)
   ☐ Abdomen / pelvis
   ☐ Bone
   ☐ Brain
   ☐ Chest
   ☐ Sinus
   ☐ Other imaging site

4 Specify other imaging site: _____________________________

5 Pathology (e.g. biopsy, cytology)
   ☐ Yes ☐ No

6 Specify sample source that supported the diagnosis of fungal infection (check all that apply)
   ☐ Brain / central nervous system (CNS)
   ☐ Eye
   ☐ Liver
   ☐ Lung (includes sputum)
   ☐ Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
   ☐ Skin
   ☐ Spleen
   ☐ Other sample source

7 Specify other sample source: _____________________________

8 Culture
   ☐ Yes ☐ No
### Hematologic Findings at Diagnosis of Infection

<table>
<thead>
<tr>
<th>Sequence Number:</th>
<th>CIBMTR Recipient ID:</th>
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<td>Specify imaging sites and sample sources that supported the diagnosis of fungal infection.</td>
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</tbody>
</table>

#### Antifungal Drugs
- **Posaconazole (Noxafil)**
- **Itraconazole (Sporanox)**
- **Caspofungin (Cancidas)**
- **Anidulafungin (Eraxis)**
- **Amphotericin products (Amphocin, Fungizone, Ambisome, Abelcet, Amphotec)**

#### Drug Therapy
- **Between 7 days prior to the date of infection diagnosis and the date of contact for this reporting period:**
- **At the end of the reporting period:**
- **30 days (± 3 days) after the date of diagnosis of infection:**

#### Infection Episode
- **Status of infection:**
  - Known
  - Ongoing
  - Improved
  - Resolved

#### Other Sample Sources
- **Blood**
- **Bone**
- **Brain / central nervous system (CNS)**
- **Eye**
- **Liver**
- **Lung**
- **Upper gastrointestinal (GI) tract**
- **Skin**
- **Spleen**
- **Other sample source**

#### Imaging Sites
- **Chest**
- **Brain**
- **Bone**
- **Abdomen / pelvis**
- **Brain / central nervous system (CNS)**
- **Upper gastrointestinal (GI) tract**
- **Other imaging site**

#### Additional Tests
- **KOH / Calcofluor / Giemsa stain**
- **Galactomannan assay**
- **1,3-Beta-D-glucan (Fungitell) assay**
- **PCR assay**

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Mail, fax or email this form to Minneapolis. Fax: 612-527-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.
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23 Specify tissue (check all that apply)
- Brain
- Eye
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Liver
- Lung
- Skin
- Other tissue

24 Specify other tissue:__________________________

Hematologic Findings at Diagnosis of Infection

Questions: 25 - 41

Provide values closest to the date of diagnosis of the infection (± 7 days)

25 Date of complete blood count: __ __ __ __ - __ __- __ __

26 WBC
- Known
- Unknown

27 Neutrophils
- Known
- Unknown

28 Platelets
- Known
- Unknown

29 Monocytes
- Known
- Unknown

30 Lymphocytes
- Known
- Unknown

31 Hemoglobin
- Known
- Unknown

32 Hematocrit
- Known
- Unknown

33 Erythrocytes
- Known
- Unknown

34 Serum creatinine
- Known
- Unknown

35 Upper limit of normal for your institution: __ __ __ __ - __ __- __ __

36 ALT (SGPT)
- Known
- Unknown

37 Upper limit of normal for your institution: __ __ __ __ - __ __- __ __

38 Antifungal Drugs (1)

Questions: 42 - 48

Specify all medications received by the recipient from 7 days prior to the date of infection diagnosis until the end of the reporting period for this form. If the recipient received the medication, please record the date that the medication started.

42 Did the recipient receive any therapy between 7 days prior to the date of infection diagnosis and the date of contact for this reporting period?
- yes
- no

Antifungal Drugs (1)

Questions: 43 - 47
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**Center:**

**CRID:**

### 43 Antifungal drugs
- Amphotericin products (Amphocin, Fungizone, Ambisome, Abelcet, Amphocil)
- Anidulafungin (Eraxis)
- Caspofungin (Cancidas)
- Fluconazole (Diflucan)
- Isavuconazole (Cresemba)
- Itraconazole (Sporanox)
- Miconazole (Mycelex)
- Posaconazole (Noxafil)
- Voriconazole (Vfend)
- Other antifungal drug

### 44 Specify other antifungal drug: _________________

### 45 Date therapy started
- Known
- Unknown

### 46 Date started: ________-______-______  Date estimated

### 47 Was this therapy still being given at 30 days (±3 days) after the date of diagnosis of infection? (for cases where 30 days (±3 days) falls in the next reporting period, indicate if the recipient was still receiving this therapy at the date of last contact)
- Yes
- No

### 48 What was the status of the infection? (at the end of the reporting period)
- Ongoing
- Improved
- Resolved
- Unknown

**First Name:**

**Last Name:**

**E-mail address:**

**Date:** ________-______-______