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

Chronic Granulomatous Disease (CGD) Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Has this patient's data been previously reported to USIDNET?

1 ☐ yes → USIDNET ID:
2 ☐ no

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.

Questions followed by the symbol 🕮 indicate additional information necessary to complete the question is referenced in the forms instruction manual.

Laboratory Studies Post-HSCT

Report the most recent findings since the date of the last report. For questions 1–3 and 6–7, also report CBC results in the Form 2100 – 100 Days Post-HSCT Data beginning at question 48, or in the Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 19.

1. Date of most recent hematologic testing: Month Day 20 Year

2. WBC: ____ . ____ Specify units: 1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L ☐ not tested

3. Lymphocytes: ____ % ☐ not tested

4. Eosinophils: ____ % ☐ not tested

5. Polymorphonuclear leukocytes (PMN): ____ % ☐ not tested

6. Hemoglobin: ____ . ____ 1 ☐ g/dL 2 ☐ g/L 3 ☐ mmol/L ☐ not tested ☐ transfused RBC < 30 days from date of most current testing

7. Platelets: ____ 1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L ☐ not tested ☐ transfused platelets < 7 days from date of most current testing

Internal use: Document number F00684 revision 1 Replaces: n/a

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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Immunoglobulin Analysis

Specify the most recent quantitative immunoglobulins measured since the date of the last report.
For questions 8–13, also report immunoglobulins in the Form 2100 – 100 Days Post-HSCT Data beginning at question 55, or in the Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 26.
For questions 16–17, also report IVIG in the Form 2100 – 100 Days Post-HSCT Data beginning at question 61, or in the Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 32.

	Value:	Specify units:	Date tested: Month Day Year	
8. IgG:	•	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	9.	☐ not tested
10. IgM:	•	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	11.	☐ not tested
12. IgA:	•	1 ☐ mg/dL 2 ☐ g/dL 3 ☐ g/L	13.	☐ not tested
14. IgE:	IU/mL		15.	☐ not tested

16. Did the recipient receive supplemental intravenous immunoglobulins (IVIG) (since the date of the last report)?
1 ☐ yes → 17. Was therapy ongoing within one month of immunoglobulin testing?
1 ☐ yes
2 ☐ no
2 ☐ no
3 ☐ unknown

Lymphocyte Analysis

Specify the most recent lymphocyte assessment measured since the date of the last report.
For questions 19 and 21–25, also report lymphocytes in the Form 2100 – 100 Days Post-HSCT Data beginning at question 71, or in the Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 42.

18. Were lymphocyte analyses performed? 🕮
1 ☐ yes →
2 ☐ no

19. Date of most recent testing performed: Month Day Year

20. Absolute lymphocyte count: → cells / µL (cells / mm^3)

	% of total lymphocytes:	– or – Value:	Specify units:	
21. CD3 (T cells): →		– or –	1 ☐ x 10^9/L ($x 10^3/mm^3$) 2 ☐ x 10^6/L	☐ not tested
22. CD4 (T helper cells): →		– or –	1 ☐ x 10^9/L ($x 10^3/mm^3$) 2 ☐ x 10^6/L	☐ not tested
23. CD8 (cytotoxic T cells): →		– or –	1 ☐ x 10^9/L ($x 10^3/mm^3$) 2 ☐ x 10^6/L	☐ not tested
24. CD20 (B lymphocyte cells): →		– or –	1 ☐ x 10^9/L ($x 10^3/mm^3$) 2 ☐ x 10^6/L	☐ not tested
25. CD56 (natural killer (NK) cells): →		– or –	1 ☐ x 10^9/L ($x 10^3/mm^3$) 2 ☐ x 10^6/L	☐ not tested

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	% of total lymphocytes:		Value:	Specify units:	
26. CD4+ / CD45RA+ (naive T cells): →		– or –		1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested
27. CD4+ / CD45RO+ (memory T cells): →		– or –		1 ☐ x 10^9/L (x 10^3/mm^3) 2 ☐ x 10^6/L	☐ not tested

Antibody Response

Specify the most recent antibody responses measured since the date of the last report.

28. Date antibody responses were assessed: Month ____ Day ____ Year 20____

Absent	Low	Normal	Not tested	
1 ☐	2 ☐	3 ☐	4 ☐	29. Diptheria
1 ☐	2 ☐	3 ☐	4 ☐	30. Protein conjugated HIB or pneumococcal vaccine
1 ☐	2 ☐	3 ☐	4 ☐	31. Tetanus

32. Unconjugated pneumococcal polysaccharide: ____ / ____
Number of serotypes producing a protective level / Total serotypes tested from vaccine

33. Conjugated pneumococcal polysaccharide: ____ / ____
Number of serotypes producing a protective level / Total serotypes tested from vaccine

Lymphocyte Function

Specify the most recent lymphocyte function measured since the date of the last report.

34. Date lymphocyte function was assessed: Month ____ Day ____ Year 20____

Absent (< 10% of control)	Low (10-30% of control)	Normal (> 30% of control)	Not tested	
1 ☐	2 ☐	3 ☐	4 ☐	35. Anti-CD3
1 ☐	2 ☐	3 ☐	4 ☐	36. Candida antigen
1 ☐	2 ☐	3 ☐	4 ☐	37. Concavalin A (ConA)
1 ☐	2 ☐	3 ☐	4 ☐	38. Phytohemagglutinin (PHA)
1 ☐	2 ☐	3 ☐	4 ☐	39. Pokeweed mitogen (PWM)
1 ☐	2 ☐	3 ☐	4 ☐	40. Tetanus antigen

Oxidative Burst

Specify the most recent oxidative burst measured since the date of the last report.

41. Date oxidative burst was assessed: Month ____ Day ____ Year 20____

42. Neutrophils with normal respiratory burst: ____ %

43. Specify evaluative technique used: _____

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Infusion Date: Month ____ Day ____ 20__ Year

CIBMTR Center Number:

Initials:

CIBMTR Center Number: ____ CIBMTR Recipient ID: ____

Clinical Features Assessed Post-HSCT

Infections Identified Post-HSCT

Specify the presence of all clinically significant infections identified since the date of the last report. If any given infection was identified, use the Codes for Commonly Reported Organisms on page 6 to report the organism present. Only report an organism once, even if it was identified at the same site in subsequent infections.

Also report infections in the Form 2100 – 100 Days Post-HSCT Data beginning at question 379, or in the Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 319.

Copy this chart to report more than three different infections identified at any one site; check here ☐ if additional pages are attached.

Site of infection?	First organism	Second organism	Third organism	Specify other organism
44. 1 ☐ yes 2 ☐ no Adenitis →	45.	46.	47.	48.
49. If adenitis was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
50. 1 ☐ yes 2 ☐ no Brain abscess →	51.	52.	53.	54.
55. If brain abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
56. 1 ☐ yes 2 ☐ no Cellulitis →	57.	58.	59.	60.
61. If cellulitis was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
62. 1 ☐ yes 2 ☐ no Furuncles →	63.	64.	65.	66.
67. If furuncles were present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
68. 1 ☐ yes 2 ☐ no Genitourinary →	69.	70.	71.	72.
73. If genitourinary infection was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
74. 1 ☐ yes 2 ☐ no Impetigo →	75.	76.	77.	78.
79. If impetigo was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
80. 1 ☐ yes 2 ☐ no Joint →	81.	82.	83.	84.
85. If joint infection was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				
86. 1 ☐ yes 2 ☐ no Liver abscess →	87.	88.	89.	90.
91. If liver abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no				

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Site of infection?		First organism	Second organism	Third organism	Specify other organism
92. 1 ☐ yes 2 ☐ no	Lung abscess → 93.		94.	95.	96.
97. If lung abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
98. 1 ☐ yes 2 ☐ no	Lymph nodes abscess → 99.		100.	101.	102.
103. If lymph nodes abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
104. 1 ☐ yes 2 ☐ no	Meningitis / encephalitis → 105.		106.	107.	108.
109. If meningitis or encephalitis was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
110. 1 ☐ yes 2 ☐ no	Osteomyelitis → 111.		112.	113.	114.
115. If osteomyelitis was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
116. 1 ☐ yes 2 ☐ no	Perirectal abscess → 117.		118.	119.	120.
121. If perirectal abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
122. 1 ☐ yes 2 ☐ no	Pneumonia → 123.		124.	125.	126.
127. If pneumonia was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
128. 1 ☐ yes 2 ☐ no	Severe or protracted diarrhea → 129.		130.	131.	132.
133. If severe or protracted diarrhea was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
134. 1 ☐ yes 2 ☐ no	Subcutaneous abscess → 135.		136.	137.	138.
139. If subcutaneous abscess was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
140. 1 ☐ yes 2 ☐ no	Systemic infection → 141.		142.	143.	144.
145. If systemic infection was present, was it a prominent feature of CGD? 1 ☐ yes 2 ☐ no					
146. 1 ☐ yes 2 ☐ no	Other infection → 147.		148.	149.	150.

151. Specify other infection site: _____

152. If other infection was present, was it a prominent feature of CGD?
1 ☐ yes
2 ☐ no

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Infusion Date: Month ____ Day ____ Year 20____

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Codes for Commonly Reported Organisms

Bacterial Infections

121 Acinetobacter
122 Actinomyces
123 Bacillus
124 Bacteroides (gracillis, uniformis, vulgaris, other species)
125 Bordetella pertussis (whooping cough)
126 Borrelia (Lyme disease)
127 Branhamella or Moraxella catarrhalis (other species)
128 Campylobacter (all species)
129 Capnocytophaga
171 Chlamydia pneumoniae
172 Other chlamydia, specify
113 Chlamydia, NOS
130 Citrobacter (freundii, other species)
131 Clostridium (all species except difficile)
132 Clostridium difficile
173 Corynebacterium jeikeium
133 Corynebacterium (all non-diptheria species)
101 Coxiella
134 Enterobacter
177 Enterococcus, vancomycin resistant (VRE)
135 Enterococcus (all species)
136 Escherichia (also E. coli)
137 Flavimonas oryzihabitans
138 Flavobacterium
139 Fusobacterium
144 Haemophilus (all species, including influenzae)
145 Helicobacter pylori
146 Klebsiella
147 Lactobacillus (bulgaricus, acidophilus, other species)
102 Legionella
103 Leptospira
148 Leptotrichia buccalis
149 Leuconostoc (all species)
104 Listeria
150 Methylobacterium
151 Micrococcus, NOS
112 Mycobacterium avium–intracellulare (MAC, MAI)
174 Mycobacterium species (cheloneae, fortuitum, haemophilum, kansasii, mucogenicum
110 Mycobacterium tuberculosis (tuberculosis, Koch bacillus)
175 Other mycobacterium, specify
176 Mycobacterium, NOS
105 Mycoplasma
152 Neisseria (gonorrhoea, meningitidis, other species)
106 Nocardia
153 Pasteurella multocida
154 Propionibacterium (acnes, avidum, granulosum, other species)
155 Proteus
156 Pseudomonas (all species except cepacia & maltophilia)
157 Pseudomonas or Burkholderia cepacia
158 Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
159 Rhodococcus
107 Rickettsia
160 Salmonella (all species)
161 Serratia marcescens
162 Shigella
163 Staphylococcus, coagulase negative (not aureus)
164 Staphylococcus aureus
165 Staphylococcus, NOS
166 Stomatococcus mucilaginosis
167 Streptococcus (all species except Enterococcus)
178 Streptococcus pneumoniae
168 Treponema (syphilis)
169 Vibrio (all species)
197 Multiple bacteria at a single site, specify bacterial codes
198 Other bacteria, specify ‡
501 Suspected atypical bacterial infection
502 Suspected bacterial infection

Fungal Infections

200 Candida, NOS
201 Candida albicans
206 Candida guillermondi
202 Candida krusei
207 Candida lusitaniae
203 Candida parapsilosis
204 Candida tropicalis
205 Candida (Torulopsis) glabrata
209 Other Candida, specify ‡
210 Aspergillus, NOS §
211 Aspergillus flavus §
212 Aspergillus fumigatus §
213 Aspergillus niger §
219 Other Aspergillus, specify ‡ §
220 Cryptococcus species
230 Fusarium species §
261 Histoplasmosis
240 Zygomycetes, NOS §
241 Mucormycosis §
242 Rhizopus §
250 Yeast, NOS
259 Other fungus, specify ‡
260 Pneumocystis (PCP / PJP)
503 Suspected fungal infection

Viral Infections

301 Herpes simplex (HSV1, HSV2)
302 Varicella (herpes zoster, chicken pox)
303 Cytomegalovirus (CMV)
304 Adenovirus
305 Enterovirus (coxsackie, echo, polio)
306 Hepatitis A (HAV)
307 Hepatitis B (HBV, Australian antigen) †
308 Hepatitis C (HCV) †
309 HIV-1 (HTLV-III) ¤
310 Influenza, NOS
323 Influenza A
324 Influenza B
311 Measles (rubeola)
312 Mumps
313 Progressive multifocal leukoencephalopathy (PML)
314 Respiratory syncytial virus (RSV)
315 Rubella (German measles)
316 Parainfluenza
317 Human herpesvirus-6 (HHV-6)
318 Epstein-Barr virus (EBV)
319 Polyoma virus (BK virus, JC virus)
320 Rotavirus
321 Rhinovirus
322 Human papilloma virus (HPV)
329 Other virus, specify ‡
504 Suspected viral infection

Parasitic Infections

402 Toxoplasma
403 Giardia
404 Cryptosporidium
409 Other parasite, specify ‡
505 Suspected parasite infection

Other Infections

509 No organism identified

‡ The codes for "other organism, specify" (codes 198, 209, 219, 259, 329 and 409) should rarely be needed; check with your microbiology lab or HSCT physician before using them.

§ For fungal infections marked with a section symbol (codes 210, 211, 212, 213, 219, 230, 240, 241, and 242), also complete a Fungal Infection (FNG) form.

† For hepatitis infections marked with a dagger symbol (codes 307 and 308), also complete a Hepatitis (HEP) form.

¤ For HIV infections marked with a currency symbol (code 309), also complete an HIV Infection (HIV) form.

* Do not report fever in the absence of infection. Report the most specific site of infection.

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Clinical Status Post-HSCT

153. Did the recipient experience any of the following clinical features (since the date of the last report)?
1 ☐ yes → Specify clinical features:
2 ☐ no

Feature present?		If present, is the feature prominent?
154. 1 ☐ yes 2 ☐ no	Autoimmune hemolytic anemia →	155. 1 ☐ yes 2 ☐ no
156. 1 ☐ yes 2 ☐ no	Delayed puberty →	157. 1 ☐ yes 2 ☐ no
158. 1 ☐ yes 2 ☐ no	Failure to thrive (weight < 5th percentile) →	159. 1 ☐ yes 2 ☐ no
160. 1 ☐ yes 2 ☐ no	Gastric outlet obstruction →	161. 1 ☐ yes 2 ☐ no
162. 1 ☐ yes 2 ☐ no	Graft versus host disease — acute →	163. 1 ☐ yes 2 ☐ no
164. 1 ☐ yes 2 ☐ no	Graft versus host disease — chronic →	165. 1 ☐ yes 2 ☐ no
166. 1 ☐ yes 2 ☐ no	Growth hormone deficiency →	167. 1 ☐ yes 2 ☐ no
168. 1 ☐ yes 2 ☐ no	Growth retardation (height < 5th percentile) →	169. 1 ☐ yes 2 ☐ no
170. 1 ☐ yes 2 ☐ no	Hypothyroidism →	171. 1 ☐ yes 2 ☐ no
172. 1 ☐ yes 2 ☐ no	Inflammatory bowel disease →	173. 1 ☐ yes 2 ☐ no
174. 1 ☐ yes 2 ☐ no	Lymphoproliferative disease →	175. 1 ☐ yes 2 ☐ no
176. 1 ☐ yes 2 ☐ no	Pulmonary fibrosis →	177. 1 ☐ yes 2 ☐ no
178. 1 ☐ yes 2 ☐ no	Systemic inflammatory process →	179. 1 ☐ yes 2 ☐ no
180. 1 ☐ yes 2 ☐ no	Thrombocytopenia (< 100 x 10^9/L) →	181. 1 ☐ yes 2 ☐ no
182. 1 ☐ yes 2 ☐ no	Urinary outlet obstruction →	183. 1 ☐ yes 2 ☐ no
184. 1 ☐ yes 2 ☐ no	Veno-occlusive disease (VOD) →	185. 1 ☐ yes 2 ☐ no
186. 1 ☐ yes 2 ☐ no	Other features →	187. 1 ☐ yes 2 ☐ no

188. Specify other features: _____

189. Did the recipient receive parenteral nutrition (since the date of the last report)?
1 ☐ yes
2 ☐ no

190. Did the recipient receive mechanical ventilation (since the date of the last report)?
1 ☐ yes
2 ☐ no

Post-HSCT Treatment for CGD

191. Was treatment given (since the date of the last report)?
1 ☐ yes → **Complete the table below**
2 ☐ no → **Continue with question 263**

Also report immunosuppressive medications given to prevent or treat GVHD in the corresponding questions on the Form 2000 — Recipient Baseline Data, 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.

Prophylactic drugs paused for < 1 week should *not* be considered as "Prophylactic Drug Stopped."

Prophylactic Drug Given?	Prophylactic Drug Stopped?	Date Stopped (Month / Day / Year 20__)	
192. Antifungal drug(s) 1 ☐ yes 2 ☐ no	193. 1 ☐ yes 2 ☐ no → 194.	____ / ____ / 20__	☐ date estimated ☐ date unknown
195. Antiviral drug(s) 1 ☐ yes 2 ☐ no	196. 1 ☐ yes 2 ☐ no → 197.	____ / ____ / 20__	☐ date estimated ☐ date unknown
198. Co-trimoxazole (Bactrim, Septra) 1 ☐ yes 2 ☐ no	199. 1 ☐ yes 2 ☐ no → 200.	____ / ____ / 20__	☐ date estimated ☐ date unknown

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Therapy paused for < 1 week should *not* be considered as "Therapy Stopped."

	Therapy Given?	Therapy Stopped?	Date Stopped (Month / Day / Year)	
201. Antithymocyte globulin (ATG, ATGAM, Thymoglobulin)	1 ☐ yes → 202. 2 ☐ no	1 ☐ yes → 203. 2 ☐ no	20	☐ date estimated ☐ date unknown
204. Corticosteroids, systemic	1 ☐ yes → 205. 2 ☐ no	1 ☐ yes → 206. 2 ☐ no	20	☐ date estimated ☐ date unknown
207. Corticosteroids, topical	1 ☐ yes → 208. 2 ☐ no	1 ☐ yes → 209. 2 ☐ no	20	☐ date estimated ☐ date unknown
210. Cyclophosphamide (CTX, Cytoxan, Neosar)	1 ☐ yes → 211. 2 ☐ no	1 ☐ yes → 212. 2 ☐ no	20	☐ date estimated ☐ date unknown
213. Cyclosporine (CsA, Neoral, Sandimmune)	1 ☐ yes → 214. 2 ☐ no	1 ☐ yes → 215. 2 ☐ no	20	☐ date estimated ☐ date unknown
216. In vivo monoclonal antibody	1 ☐ yes → 2 ☐ no			

Specify monoclonal antibody:

	Therapy Given?	Therapy Stopped?	Date Stopped (Month / Day / Year)	
217. Alemtuzumab (Campath)	1 ☐ yes → 218. 2 ☐ no	1 ☐ yes → 219. 2 ☐ no	20	☐ date estimated ☐ date unknown
220. Daclizumab (anti-CD25, Zenapax)	1 ☐ yes → 221. 2 ☐ no	1 ☐ yes → 222. 2 ☐ no	20	☐ date estimated ☐ date unknown
223. Etanercept (Enbrel)	1 ☐ yes → 224. 2 ☐ no	1 ☐ yes → 225. 2 ☐ no	20	☐ date estimated ☐ date unknown
226. Infliximab (anti-TNF-α, Remicade)	1 ☐ yes → 227. 2 ☐ no	1 ☐ yes → 228. 2 ☐ no	20	☐ date estimated ☐ date unknown
229. Muromonab (anti-CD3, OKT3)	1 ☐ yes → 230. 2 ☐ no	1 ☐ yes → 231. 2 ☐ no	20	☐ date estimated ☐ date unknown
232. Rituximab (anti-CD20, Rituxan, MabThera)	1 ☐ yes → 233. 2 ☐ no	1 ☐ yes → 234. 2 ☐ no	20	☐ date estimated ☐ date unknown
235. Other monoclonal antibody	1 ☐ yes → 236. 2 ☐ no	1 ☐ yes → 237. 2 ☐ no	20	☐ date estimated ☐ date unknown

238. Specify other monoclonal antibody: _____

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CIBMTR Recipient ID:

	Therapy Given?	Therapy Stopped?	Date Stopped (Month / Day / Year 20__)	
239. Lenalidomide (Revlimid)	1 ☐ yes → 240. / 2 ☐ no	1 ☐ yes → 241. / 2 ☐ no		☐ date estimated ☐ date unknown
242. Mycophenolate mofetil (MMF, Cellcept)	1 ☐ yes → 243. / 2 ☐ no	1 ☐ yes → 244. / 2 ☐ no		☐ date estimated ☐ date unknown
245. Photopheresis / extracorporeal phototherapy (ECP)	1 ☐ yes → 246. / 2 ☐ no	1 ☐ yes → 247. / 2 ☐ no		☐ date estimated ☐ date unknown
248. Sirolimus (Rapamune)	1 ☐ yes → 249. / 2 ☐ no	1 ☐ yes → 250. / 2 ☐ no		☐ date estimated ☐ date unknown
251. Tacrolimus (FK506, Prograf)	1 ☐ yes → 252. / 2 ☐ no	1 ☐ yes → 253. / 2 ☐ no		☐ date estimated ☐ date unknown
254. Thalidomide (Thalomid)	1 ☐ yes → 255. / 2 ☐ no	1 ☐ yes → 256. / 2 ☐ no		☐ date estimated ☐ date unknown
257. Other immunosuppressive drug	1 ☐ yes → 258. / 2 ☐ no	1 ☐ yes → 259. / 2 ☐ no		☐ date estimated ☐ date unknown

260. Specify other immunosuppressive drug: _____

261. Did the recipient receive any other significant treatment(s) for CGD (since the date of the last report)?
1 ☐ yes → 262. Specify other treatment(s): _____
2 ☐ no

Status of Hematologic Engraftment

This section refers to quantitative analyses utilizing discriminating DNA markers. Peripheral blood cells must undergo separation or sorting into T, B, or lymphoid vs. myeloid populations to perform this determination. If RFLP analyses indicate only donor type hematopoiesis, mark T-cell, B-cell, and myeloid as "predominantly or completely donor."

Also report chimerism in the Form 2100 – 100 Days Post-HSCT Data beginning at question 77 or Form 2200 — Six Months to Two Years Post-HSCT Data beginning at question 48.

263. What is the current status of T-cell engraftment?
1 ☐ predominantly or completely donor (≥ 80% donor chimerism)
2 ☐ mixed chimerism (5–80% donor)
3 ☐ only host T-cells detected (< 5% donor)
4 ☐ unknown

264. Most recent date T-cell engraftment was assessed: Month ____ Day ____ Year 20____ ☐ date unknown

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).

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 Number: CIBMTR Recipient ID:

265. What is the current status of B-cell engraftment?
1 ☐ predominantly or completely donor (≥ 80% donor chimerism)
2 ☐ mixed chimerism (5–80% donor)
3 ☐ only host B-cells detected (< 5% donor)
4 ☐ unknown

266. Most recent date B-cell engraftment was assessed: Month ____ Day ____ 20__ Year ☐ date unknown

267. What is the current status of myeloid engraftment?
1 ☐ predominantly or completely donor (≥ 80% donor chimerism)
2 ☐ mixed chimerism (5–80% donor)
3 ☐ only host myeloid cells detected (< 5% donor)
4 ☐ unknown

268. Most recent date myeloid engraftment was assessed: Month ____ Day ____ 20__ Year ☐ date unknown

269. Signed: _____
Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____

Internal use: Document number F00684 revision 1 Replaces: n/a

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).