ERROR CORRECTION FORM

CIBMTR Recipient ID: 
Initials: 

CIBMTR Center Number: 

Today’s Date: 
Month Day Year

Infusion Date: 
Month Day Year

CIBMTR Center Number: 

CIBMTR Recipient ID: 

Today’s Date: 
Month Day Year

Date of HSCT for which this form is being completed: 

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

Product type: 
- marrow
- PBSC
- cord blood
- multiple cord blood units infused
- other product, specify:

Visit: 
- 6 months
- 1 year
- 2 years

Visit:
- 6 months
- 1 year
- 2 years

Six Months to Two Years
Post-HSCT Data
Registry Use Only

Sequence Number: 

Date Received: 

Information should come from an actual examination by the Transplant Center physician, or the local physician
who is following the recipient post-HSCT. Questions followed by the symbol & indicate additional information
necessary to complete the question is referenced in the forms instruction manual; &A indicates an appendix.

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

2. Did the recipient receive a subsequent HSCT (bone marrow, mobilized peripheral blood
stem cells, cord blood) since the date of contact from the last report? 

- yes
- no, recipient’s initial hematopoietic recovery was recorded on a previous report
- no, ANC ≥ 500/mm³ was not achieved*, and there was no evidence of recurrent disease
in the bone marrow post-HSCT
- no, recipient’s ANC never dropped below 500/mm³ at any time after the start of the
preparative regimen

3. Specify the recipient’s survival status at the date of actual contact:

- alive
- dead

4. Has the recipient received a donor cellular infusion (DCI) since the date of contact from the last report? 

- yes
- no

Granulopoiesis / Neutrophil Recovery

* To report dates in this section, use the first of 3 consecutive laboratory values obtained on different days.

5. Did the recipient achieve an initial hematopoietic recovery (ANC ≥ 500/mm³ for three consecutive lab values obtained on different
days) since the date of the last report? (check only one)

- yes
- no, recipient’s initial hematopoietic recovery was recorded on a previous report
- no, ANC ≥ 500/mm³ was not achieved*, and there was no evidence of recurrent disease
in the bone marrow
- no, ANC ≥ 500/mm³ was not achieved*, and there was documented persistent disease
in the bone marrow post-HSCT
- no, recipient’s ANC never dropped below 500/mm³ at any time after the start of the
preparative regimen

Continue with question 15
Continue with question 15

Mail a copy of this form to your designated campus (Milwaukee or Minneapolis). Retain the original at
the Transplant Center.
7. Following the initial hematopoietic recovery (ANC \(\geq 500/\text{mm}^3\) for three consecutive lab values obtained on different days), did the recipient experience a subsequent decline in ANC to < 500/\(\text{mm}^3\) for \(\geq 3\) days since the date of the last report?

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. yes</td>
</tr>
<tr>
<td>2. no</td>
</tr>
</tbody>
</table>

8. Date of decline in ANC to < 500/\(\text{mm}^3\) for \(\geq 3\) days (first of 3 days that ANC declined):

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

Actual CBC on first day of decline:

9. WBC: [ ] x 10^9/L (x 10^3/mm^3)

10. Neutrophils: [ ] %

11. Did the recipient recover and maintain ANC \(\geq 500/\text{mm}^3\) following the decline?

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. yes</td>
</tr>
<tr>
<td>2. no</td>
</tr>
</tbody>
</table>

12. Date of ANC recovery:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

CBC on first day of recovery:

13. WBC: [ ] x 10^9/L (x 10^3/mm^3)

14. Neutrophils: [ ] %

---

**Megakaryopoiesis / Platelet Recovery**

* This section relates to initial platelet recovery. All dates reflect no transfusions in the previous 7 days. To report dates in this section, use the first of 3 consecutive laboratory values obtained on different days.

15. Was an initial platelet count of \(\geq 20\times 10^9/\text{L}\) achieved since the date of the last report?

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. yes</td>
</tr>
<tr>
<td>2. no</td>
</tr>
</tbody>
</table>

16. Date platelets \(\geq 20\times 10^9/\text{L}\): *

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. date estimated</td>
</tr>
<tr>
<td>2. date unknown</td>
</tr>
</tbody>
</table>

Continue with question 19

17. Was an initial platelet count of \(\geq 50\times 10^9/\text{L}\) achieved since the date of the last report?

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. yes</td>
</tr>
<tr>
<td>2. no</td>
</tr>
</tbody>
</table>

18. Date platelets \(\geq 50\times 10^9/\text{L}\): *

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. date estimated</td>
</tr>
<tr>
<td>2. date unknown</td>
</tr>
</tbody>
</table>

---

CIBMTR Recipient ID:

CIBMTR Center Number:

Visit:

- 6 months
- 1 year
- 2 years

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

19. Date of most recent hematologic testing: [Month] [Day] [Year]

20. WBC: [ ] 1 x 10^9/L (x 10^3/mm³) □ not tested
   [ ] 2 x 10^9/L

21. Neutrophils: [ ] % □ not tested

22. Lymphocytes: [ ] % □ not tested

23. Hemoglobin: [ ] g/dL □ not tested □ transfused RBC < 30 days from date of most current testing
   [ ] g/L
   [ ] mmol/L

24. Hematocrit: [ ] % □ not tested □ transfused RBC < 30 days from date of most current testing
   [ ] g/dL
   [ ] g/L

25. Platelets: [ ] 1 x 10^10/L (x 10^3/mm³) □ not tested □ transfused platelets < 7 days from date of most current testing
   [ ] 2 x 10^10/L

**Immune Reconstitution**

Specify the immunoglobulin values from the most recent testing:

26. IgG: [ ] □ 1 mg/dL □ 2 g/L □ 3 g/L □ not tested

28. IgM: [ ] □ 1 mg/dL □ 2 g/L □ 3 g/L □ not tested

30. IgA: [ ] □ 1 mg/dL □ 2 g/L □ 3 g/L □ not tested

32. Did the recipient receive supplemental intravenous immunoglobulins (IVIG) since the date of the last report?
   1 □ yes 2 □ no

33. Was therapy ongoing within one month of immunglobulin testing?
   1 □ yes 2 □ no

Indication(s) for use:

34. 1 □ yes 2 □ no Prophylaxis for low IgG with no active infection (polyclonal IV gamma globulin / IVIG)

35. 1 □ yes 2 □ no Prophylaxis for cytomegalovirus (CMV) infection (CMV / hyperimmune gamma globulin)

36. 1 □ yes 2 □ no Treatment for CMV infection

37. 1 □ yes 2 □ no Treatment for respiratory syncytial virus (RSV) infection

38. 1 □ yes 2 □ no Treatment for infection with low IgG (not CMV or RSV)

39. 1 □ yes 2 □ no Other indication

40. Specify other indication:
41. Were lymphocyte analyses performed since the date of the last report? □
   1 ☐ yes
   2 ☐ no

42. Date of most recent testing performed: □
   Value: Specify units:
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

43. CD3 □
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

44. CD4 □
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

45. CD8 □
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

46. CD20 □
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

47. CD56 □
   1 ☐ $x 10^9/L$ (x $10^3/mm^3$)
   2 ☐ $x 10^6/L$

The next three sections relate to chimerisms and graft-vs-host disease from allogeneic HSCTs only. If this was an autologous HSCT, continue with the Infection section at question 289.

**Chimerism Studies**

48. Allogeneic HSCTs only: Were chimerism studies performed since the date of the last report?
   1 ☐ yes
   2 ☐ no

49. Are chimerism laboratory reports attached to this form?
   1 ☐ yes
   2 ☐ no

50. Were infusions from more than one donor given?
   1 ☐ yes
   2 ☐ no
   Continue with Chimerism Studies for multiple donors at question 132.

51. Specify donor gender:
   1 ☐ male
   2 ☐ female
   Continue with Chimerism Studies for single donor at question 52.

2 ☐ no
Continue with question 162
### Chimerism Studies

Provide date(s), method(s) and other information for all chimerism studies performed prior to date of contact (question 1).

<table>
<thead>
<tr>
<th>Date (Month Day Year)</th>
<th>Number of Total Cells Examined</th>
<th>Method</th>
<th>Cell Type</th>
<th>Donor Cells</th>
<th>Host Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>132. NMDP donor —or—</td>
<td>133. Donor / infant blood unit ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>134. NMDP donor —or—</td>
<td>135. Non-NMDP donor / infant blood unit ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>136. NMDP cord —or—</td>
<td>137. Non-NMDP cord blood unit ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>138. NMDP donor —or—</td>
<td>139. Donor / infant date of birth:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>140. NMDP donor —or—</td>
<td>141. Non-NMDP donor / infant date of birth:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Multiple Donors

Copy this page to report more than 3 tests.

<table>
<thead>
<tr>
<th>Date (Month Day Year)</th>
<th>Number of Total Cells Examined</th>
<th>Method</th>
<th>Cell Type</th>
<th>Donor Cells</th>
<th>Host Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>142. NMDP donor —or—</td>
<td>143. Donor / infant blood unit ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>144. NMDP donor —or—</td>
<td>145. Non-NMDP donor / infant blood unit ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>146. NMDP donor —or—</td>
<td>147. Non-NMDP donor / infant date of birth:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>148. NMDP donor —or—</td>
<td>149. Non-NMDP donor / infant date of birth:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**ERROR CORRECTION FORM**

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

162. Did engraftment syndrome occur since the date of the last report?
1 o yes
2 o no

163. Date of onset: Month Day Year

Specify symptoms of engraftment syndrome:
164. 1 o yes 2 o no Capillary leak syndrome
165. 1 o yes 2 o no Fever
166. 1 o yes 2 o no Skin rash

167. Specify amount of body surface affected: %

168. Was engraftment syndrome treated with corticosteroids?
1 o yes
2 o no

Acute Graft vs. Host Disease (GVHD)

169. Did acute GVHD develop or persist (or a flare-up that was more severe) since the date of the last report?
1 o yes
2 o no

170. Date of acute GVHD diagnosis: Month Day Year

171. Was the diagnosis based on evidence from a biopsy (histology)?
1 o yes
2 o no

Specify result(s):
172. 1 o yes 2 o no 3 o not inclusive tested Gastrointestinal (GI)
173. 1 o yes 2 o no 3 o 4 o Liver
174. 1 o yes 2 o no 3 o 4 o Lung
175. 1 o yes 2 o no 3 o 4 o Skin
176. 1 o yes 2 o no 3 o 4 o Other site

177. Specify other site:

178. Is a copy of the pathology report attached?
1 o yes
2 o no

179. Was the diagnosis based on clinical evidence?
1 o yes
2 o no

180. Maximum overall grade of acute GVHD:
1 o I
2 o II
3 o III
4 o IV

181. Is acute GVHD still present at the date of contact for this report (question 1)?
1 o yes
2 o no
3 o progressed to chronic GVHD
4 o unknown
List the maximum severity of organ involvement:

182. Skin:
1. no skin acute GVHD / rash not attributable to acute GVHD
2. stage 0 – no rash
3. stage 1 – maculopapular rash, < 25% of body surface
4. stage 2 – maculopapular rash, 25–50% of body surface
5. stage 3 – generalized erythroderma
6. stage 4 – generalized erythroderma with bullae formation and desquamation

183. Lower intestinal tract: (use mL/day for adult recipients and mL/m²/day for pediatric recipients)
1. no gut acute GVHD / diarrhea not attributable to acute GVHD
2. stage 0 – no diarrhea
3. stage 0 – diarrhea < 500 mL/day or < 280 mL/m²/day
4. stage 1 – diarrhea > 500 but < 1000 mL/day or 280-555 mL/m²/day
5. stage 2 – diarrhea > 1000 but < 1500 mL/day or 556-833 mL/m²/day
6. stage 3 – diarrhea > 1500 mL/day or > 833 mL/m²/day
7. stage 4 – severe abdominal pain, with or without ileus

184. Upper intestinal tract:
1. stage 0 – no persistent nausea or vomiting
2. stage 1 – persistent nausea or vomiting

185. Liver:
1. no liver acute GVHD / bilirubin level not attributable to acute GVHD
2. stage 0 – bilirubin < 2.0 mg/dL (< 34 µmol/L)
3. stage 1 – bilirubin 2.0–3.0 mg/dL (34–52 µmol/L)
4. stage 2 – bilirubin 3.1–6.0 mg/dL (53–103 µmol/L)
5. stage 3 – bilirubin 6.1–15.0 mg/dL (104–256 µmol/L)
6. stage 4 – bilirubin > 15.0 mg/dL (> 256 µmol/L)

186. Other clinical organ involvement?
1. yes
2. no

Specify site:
187. Lung
188. Other site
189. Specify other site:

190. Was specific therapy used to treat acute GVHD since the date of the last report?
1. yes
2. no

Specify therapy administered to treat acute GVHD:
191. ALS, ALG, ATS, ATG
192. Specify source:
1. horse
2. rabbit
3. other
193. Specify source:
194. Corticosteroids (systemic)
195. Corticosteroids (topical)
196. Cyclosporine (CSA) (Sandimmune, Neoral)
197. ECP (extra-corporeal photopheresis)
198. FK 506 (Tacrolimus, Prograf)
199. In vivo monoclonal antibody

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>200. Anti CD 25 (Zenapax, Daclizumab, AntiTAC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>201. Specify anti CD25:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>202.</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>203.</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>204.</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>205. Other in vivo monoclonal antibody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>206. Specify antibody:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

207. In vivo immunotoxin

|   | yes | no |

208. Specify immunotoxin:

209. Methotrexate (MTX) (Amethopterin)

|   | yes | no |

210. Mycophenolate mofetil (MMF) (CellCept)

|   | yes | no |

211. Sirolimus (Rapamycin, Rapamune)

|   | yes | no |

212. Ursodiol

|   | yes | no |

213. Blinded randomized trial

|   | yes | no |

214. Specify trial agent:

215. Other agent

|   | yes | no |

216. Specify other agent:
Chronic Graft vs. Host Disease (GVHD)

217. Did chronic GVHD develop or persist (or a flare-up that was more severe) since the date of the last report?
1 o yes
2 o no
3 o no symptoms, but recipient is receiving treatment
4 o unknown
Continue with 287
Continue with 255
Continue with 287

218. Date of chronic GVHD diagnosis:
Month Day Year

219. Onset of chronic GVHD was:
1 o progressive (acute GVHD progressed directly to chronic GVHD)
2 o interrupted (acute GVHD resolved, then chronic GVHD developed)
3 o de novo (acute GVHD never developed)
4 o chronic GVHD flare (symptoms reactivated within 30 days of drug tapering or discontinuation)

220. Karnofsky / Lansky score at diagnosis of chronic GVHD:

221. Platelet count at diagnosis of chronic GVHD:

222. Diagnosis was based on:
1 o histologic evidence / biopsy proven
2 o clinical evidence
3 o both
4 o unknown

223. Maximum grade of chronic GVHD:
1 o limited – localized skin involvement and/or hepatic dysfunction due to chronic GVHD
2 o extensive – one or more of the following:
   - generalized skin involvement; or,
   - liver histology showing chronic aggressive hepatitis, bridging necrosis or cirrhosis; or,
   - involvement of eye: Schirmer’s test with < 5 mm wetting; or
   - involvement of minor salivary glands or oral mucosa demonstrated on labial biopsy; or
   - involvement of any other target organ

224. Overall severity of chronic GVHD:
1 o mild – signs and symptoms of chronic GVHD do not interfere substantially with function and do not progress once appropriately treated with local therapy or standard systemic therapy (corticosteroids and/or cyclosporine or FK 506)
2 o moderate – signs and symptoms of chronic GVHD interfere somewhat with function despite appropriate therapy or are progressive through first line systemic therapy (corticosteroids and/or cyclosporine or FK 506)
3 o severe – signs and symptoms of chronic GVHD limit function substantially despite appropriate therapy or are progressive through second line therapy

Organ Involvement
Indicate if there was organ involvement with chronic GVHD:

225. o yes 2 o no Sclerosis of skin
226. o yes 2 o no

227. o yes 2 o no Other skin or hair involvement (rash, ulcers, pruritus or itching, dyspigmentation, alopecia, pruritus changes, etc.)
228. o yes 2 o no

229. o yes 2 o no Eyes (xerophthalmia (dry eyes), abnormal Schirmer’s test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)
230. o yes 2 o no

231. o yes 2 o no Mouth (lichenoid changes, mucositis / ulcers, erythema, etc.)
232. o yes 2 o no
### Chronic Graft-Versus-Host Disease (GVHD) Symptoms

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>233.</strong> Bronchiolitis obliterans</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>234.</strong> Other lung involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>235.</strong> Gastrointestinal tract (esophageal involvement, chronic nausea / vomiting, chronic diarrhea, malabsorption, abdominal pain / cramps, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>236.</strong> Liver</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>237.</strong> Genitourinary tract (vaginitis / stricture, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>238.</strong> Musculoskeletal (arthritis, contractures, myositis, myasthenia, etc.)</td>
<td></td>
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</tr>
<tr>
<td><strong>239.</strong> Thrombocytopenia (&lt; 100 x 10⁹/L)</td>
<td></td>
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</tr>
<tr>
<td><strong>240.</strong> Eosinophilia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>241.</strong> Autoantibodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>242.</strong> Other hematologic involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>243.</strong> Serositis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>244.</strong> Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>245.</strong> Other organ involvement from chronic GVHD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Was specific therapy used to treat chronic GVHD?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Specify therapy:

- **256.** ALS, ALG, ATS, ATG

#### Specify source:

- **257.**
  - horse
  - rabbit
  - other

#### Other in vivo monoclonal antibody

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Specify antibody:

- **268.** Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
  - yes
  - no

- **269.**

- **270.** Campath
- **271.** Etaercept (Entreliz)
- **272.** Infliximab (Remicade)
- **273.** Other in vivo monoclonal antibody
  - yes
  - no

- **274.**

- **275.** Lamprene (Clofazimine)
- **276.** Mycophenolate mofetil (MMF) (CellCept)
- **277.** Pentostatin
286. Are symptoms of chronic GVHD still present on the date of actual contact (or present at the time of death)?

1 □ yes  ☐ no

287. Is the recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD? □

1 □ yes 2 □ no 3 □ unknown

288. Date final treatment administered: Month Day Year

☐ date unknown  ☐ date previously reported

Infection

289. Did the recipient receive any of the following agents for infection prophylaxis since the date of the last report? □

(Report prophylaxis immunoglobulins at questions 34–35.)

Specify agent(s) given:

1 □ yes 2 □ no 3 □ unknown
<table>
<thead>
<tr>
<th>Organism</th>
<th>Site</th>
<th>Date of Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

‡ 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.
### Codes for Commonly Reported Organisms

<table>
<thead>
<tr>
<th>Code</th>
<th>Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>121</td>
<td>Acinetobacter</td>
</tr>
<tr>
<td>122</td>
<td>Actinomyces</td>
</tr>
<tr>
<td>123</td>
<td>Bacillus</td>
</tr>
<tr>
<td>124</td>
<td>Bacteroides (gracilis, uniformis, vulgaris, other species)</td>
</tr>
<tr>
<td>125</td>
<td>Bordetella pertussis (whooping cough)</td>
</tr>
<tr>
<td>126</td>
<td>Brucella (brucellosis)</td>
</tr>
<tr>
<td>127</td>
<td>Branhamella or Moraxella</td>
</tr>
<tr>
<td>128</td>
<td>Campylobacter (all species)</td>
</tr>
<tr>
<td>129</td>
<td>Capnocytophaga</td>
</tr>
<tr>
<td>130</td>
<td>C. diphtheriae (friendi, other species)</td>
</tr>
<tr>
<td>131</td>
<td>Clostridium (all species except difficile)</td>
</tr>
<tr>
<td>132</td>
<td>Clostridium difficile</td>
</tr>
<tr>
<td>133</td>
<td>Corynebacterium (all non-diphtheria species)</td>
</tr>
<tr>
<td>134</td>
<td>Enterobacter</td>
</tr>
<tr>
<td>135</td>
<td>Enterococcus, vancomycin resistant (VRE)</td>
</tr>
<tr>
<td>136</td>
<td>Escherichia coli</td>
</tr>
<tr>
<td>137</td>
<td>Flavimonas oryzae</td>
</tr>
<tr>
<td>138</td>
<td>Flavobacterium</td>
</tr>
<tr>
<td>139</td>
<td>Fusobacterium</td>
</tr>
<tr>
<td>140</td>
<td>Helicobacter pylori</td>
</tr>
<tr>
<td>141</td>
<td>Haemophilus (all species, including influenzae)</td>
</tr>
<tr>
<td>142</td>
<td>Haemophonus</td>
</tr>
<tr>
<td>143</td>
<td>Helicobacter pylori</td>
</tr>
<tr>
<td>144</td>
<td>Haemophilus (all species, including influenzae)</td>
</tr>
<tr>
<td>145</td>
<td>Helicobacter pylori</td>
</tr>
<tr>
<td>146</td>
<td>K. oxytoca</td>
</tr>
<tr>
<td>147</td>
<td>Lactobacillus (bifidus, acidophilus, other species)</td>
</tr>
<tr>
<td>148</td>
<td>Legioella</td>
</tr>
<tr>
<td>149</td>
<td>Leptospira</td>
</tr>
<tr>
<td>150</td>
<td>Listeria</td>
</tr>
<tr>
<td>151</td>
<td>Mycobacterium avium-intracellulare (MAC, MAI)</td>
</tr>
<tr>
<td>152</td>
<td>Neisseria (gonorrhoea, meningitidis, other species)</td>
</tr>
<tr>
<td>153</td>
<td>Nocardia</td>
</tr>
<tr>
<td>154</td>
<td>Pasteurella multocida</td>
</tr>
<tr>
<td>155</td>
<td>Proteus</td>
</tr>
<tr>
<td>156</td>
<td>Pseudomonas (all species except cepacia &amp; maltophilia)</td>
</tr>
<tr>
<td>157</td>
<td>Pseudomonas or Burkholderia cepacia</td>
</tr>
<tr>
<td>158</td>
<td>Pseudomonas or Stenotrophomonas or Rhizomonas maltophilia</td>
</tr>
<tr>
<td>159</td>
<td>Rhodococcus</td>
</tr>
<tr>
<td>160</td>
<td>Salmonella (all species)</td>
</tr>
<tr>
<td>161</td>
<td>Serratia marcescens</td>
</tr>
<tr>
<td>162</td>
<td>Shigella</td>
</tr>
<tr>
<td>163</td>
<td>Staphylococcus coagulase negative (not aureus)</td>
</tr>
<tr>
<td>164</td>
<td>Staphylococcus aureus</td>
</tr>
<tr>
<td>165</td>
<td>Staphylococcus, NOS</td>
</tr>
<tr>
<td>166</td>
<td>Stomatococcus mucilaginosus</td>
</tr>
<tr>
<td>167</td>
<td>Streptococcus (all species except Enterococcus)</td>
</tr>
<tr>
<td>168</td>
<td>Streptococcus pneumoniae</td>
</tr>
<tr>
<td>169</td>
<td>Treponema (syphilis)</td>
</tr>
<tr>
<td>170</td>
<td>Vibrio (all species)</td>
</tr>
<tr>
<td>171</td>
<td>Vitreosphilus (synonym)</td>
</tr>
<tr>
<td>172</td>
<td>Other virus, specify ‡</td>
</tr>
<tr>
<td>173</td>
<td>Virus, NOS</td>
</tr>
<tr>
<td>174</td>
<td>Yeast, NOS</td>
</tr>
<tr>
<td>175</td>
<td>Other parasite, specify ‡</td>
</tr>
<tr>
<td>176</td>
<td>Pneumocystis (PCP / PJP)</td>
</tr>
</tbody>
</table>

### Codes for Common Sites of Infection

<table>
<thead>
<tr>
<th>Code</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blood / buffy coat</td>
</tr>
<tr>
<td>2</td>
<td>Disseminated – generalized, isolated at 3 or more distinct sites</td>
</tr>
<tr>
<td>3</td>
<td>Central nervous system, not specified</td>
</tr>
<tr>
<td>4</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>5</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>6</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>7</td>
<td>Central Nervous System</td>
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<td>8</td>
<td>Central Nervous System</td>
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<td>9</td>
<td>Central Nervous System</td>
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<td>10</td>
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<td>11</td>
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<td>12</td>
<td>Central Nervous System</td>
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<tr>
<td>13</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>14</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>15</td>
<td>Gallbladder and biliary tree (not hepatitis)</td>
</tr>
<tr>
<td>16</td>
<td>Small intestine</td>
</tr>
<tr>
<td>17</td>
<td>Large intestine</td>
</tr>
<tr>
<td>18</td>
<td>Feces / stool</td>
</tr>
<tr>
<td>19</td>
<td>Peritonaeum</td>
</tr>
<tr>
<td>20</td>
<td>Liver</td>
</tr>
<tr>
<td>21</td>
<td>Gastrointestinal tract, not specified</td>
</tr>
<tr>
<td>22</td>
<td>Gastrointestinal tract, not specified</td>
</tr>
<tr>
<td>23</td>
<td>Gastrointestinal tract, not specified</td>
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<td>24</td>
<td>Gastrointestinal tract, not specified</td>
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<td>25</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>26</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>27</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>28</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>29</td>
<td>Gastrointestinal tract, not specified</td>
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<td>30</td>
<td>Gastrointestinal tract, not specified</td>
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<td>31</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>32</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>33</td>
<td>Gastrointestinal tract, not specified</td>
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<td>34</td>
<td>Gastrointestinal tract, not specified</td>
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<td>35</td>
<td>Gastrointestinal tract, not specified</td>
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<td>36</td>
<td>Gastrointestinal tract, not specified</td>
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<td>37</td>
<td>Gastrointestinal tract, not specified</td>
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<td>38</td>
<td>Gastrointestinal tract, not specified</td>
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<tr>
<td>39</td>
<td>Gastrointestinal tract, not specified</td>
</tr>
<tr>
<td>40</td>
<td>Gastrointestinal tract, not specified</td>
</tr>
<tr>
<td>41</td>
<td>Urine, kidneys, renal pelvis, ureters and bladder</td>
</tr>
<tr>
<td>42</td>
<td>Prostate</td>
</tr>
<tr>
<td>43</td>
<td>Testes</td>
</tr>
<tr>
<td>44</td>
<td>Fallopian tubes, uterus, cervix</td>
</tr>
<tr>
<td>45</td>
<td>Vagina</td>
</tr>
<tr>
<td>46</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>47</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>48</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>49</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>50</td>
<td>Skin, not otherwise specified</td>
</tr>
<tr>
<td>51</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>52</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>53</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>54</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>55</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>56</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>57</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>58</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>59</td>
<td>Genito-urinary tract, not specified</td>
</tr>
<tr>
<td>60</td>
<td>Genito-urinary tract, not specified</td>
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</table>

### Other Infections

<table>
<thead>
<tr>
<th>Code</th>
<th>Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>Central venous catheter, not specified</td>
</tr>
<tr>
<td>62</td>
<td>Catheter insertion or exit site</td>
</tr>
<tr>
<td>63</td>
<td>Catheter tip</td>
</tr>
<tr>
<td>64</td>
<td>Eyes</td>
</tr>
<tr>
<td>65</td>
<td>Ears</td>
</tr>
<tr>
<td>66</td>
<td>Joints</td>
</tr>
<tr>
<td>67</td>
<td>Bone marrow</td>
</tr>
<tr>
<td>68</td>
<td>Bone cortex (osteomyelitis)</td>
</tr>
<tr>
<td>69</td>
<td>Muscle (excluding cardiac)</td>
</tr>
<tr>
<td>70</td>
<td>Cardiac (endocardium, myocardium, pericardium)</td>
</tr>
<tr>
<td>71</td>
<td>Lymph nodes</td>
</tr>
<tr>
<td>72</td>
<td>Spleen</td>
</tr>
</tbody>
</table>

**CIBMTR Form 2200 revision 2 (page 14 of 25) June 2009**
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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
Organ Function

Pulmonary Function

350. Did the recipient develop interstitial pneumonitis (IPn or ARDS) and/or idiopathic pneumonia syndrome (IPS) since the date of the last report?

Interstitial pneumonitis / idiopathic pneumonia syndrome is characterized on chest x-ray by hypoxia and diffuse interstitial infiltrates not caused by fluid overload.

(Report bacterial and fungal pneumonia in Infection section [questions 319–347].)

1 □ yes
2 □ no

351. Date of diagnosis of IPn / IPS:

Month Day Year

352. Were diagnostic tests done (other than radiographic studies)?

1 □ yes
2 □ no

Diagnosis was evaluated by:

353. □ yes □ no Bronchoalveolar lavage (BAL)
354. □ yes □ no Transbronchial biopsy
355. □ yes □ no Open / thorascopic (VATS) lung biopsy
356. □ yes □ no Autopsy
357. □ yes □ no Other test

358. Specify other test:

359. Was an organism isolated?

1 □ yes
2 □ no / idiopathic

Etiology:

360. □ yes □ no Adenovirus
361. □ yes □ no Cytomegalovirus (CMV)
362. □ yes □ no Herpes simplex (HSV1, HSV2)
363. □ yes □ no Human herpes virus type 6 (HHV6)
364. □ yes □ no Parainfluenza
365. □ yes □ no Respiratory syncytial virus (RSV)
366. □ yes □ no Toxoplasma
367. □ yes □ no Other virus

368. Specify other virus:

369. □ yes □ no Other organism

370. Specify organism:

371. Did the recipient experience two or more episodes of IPn / IPS since the date of the last report?

1 □ yes
2 □ no

Copy and complete this page for each episode.

372. Are extra pages attached?

1 □ yes
2 □ no
CIBMTR Recipient ID:

CIBMTR Center Number:

373. Did the recipient develop non-infectious pulmonary abnormalities (other than IPn / IPS / ARDS) since the date of the last report?

1 yes 2 no

374. Did the recipient develop bronchiolitis obliterans since the date of the last report?

1 yes 2 no

375. Date of diagnosis: [ ] [ ] [ ]

376. Were diagnostic tests done?

1 yes 2 no

Diagnosis was evaluated by:

377. Bronchoalveolar lavage (BAL)

378. Transbronchial biopsy

379. Open / thoracoscopic (VATS) lung biopsy

380. Autopsy

381. Other

382. Specify:

383. Did the recipient develop pulmonary hemorrhage?

1 yes 2 no

384. Date of diagnosis: [ ] [ ] [ ]

385. Were diagnostic tests done?

1 yes 2 no

Diagnosis was evaluated by:

386. Bronchoalveolar lavage (BAL)

387. Transbronchial biopsy

388. Open / thoracoscopic (VATS) lung biopsy

389. Autopsy

390. Other

391. Specify:

392. Did the recipient develop cryptogenic organizing pneumonia (COP)?

1 yes 2 no

393. Date of diagnosis: [ ] [ ] [ ]

394. Were diagnostic tests done?

1 yes 2 no

Diagnosis was evaluated by:

395. Bronchoalveolar lavage (BAL)

396. Transbronchial biopsy

397. Open / thoracoscopic (VATS) lung biopsy

398. Autopsy

399. Other

400. Specify:

401. Did the recipient develop any other non-infectious pulmonary abnormalities?

1 yes 2 no

402. Specify other pulmonary abnormality:

403. Did the recipient receive endotracheal intubation or mechanical ventilation since the date of the last report?

1 yes 2 no

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

404. Did the recipient develop non-infectious liver toxicity (excluding GVHD) since the date of the last report?

- [ ] yes
- [x] no

405. Date of diagnosis: [ ] [ ] [ ]

**Etiology:**

- [x] Cirrhosis
- [ ] Veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS)

408. Did the recipient receive treatment for VOD?

- [ ] yes
- [x] no

410. Did VOD resolve?

- [ ] yes
- [x] no

411. Maximum bilirubin since last report: [ ] [ ] [ ]

412. [ ] yes  [ ] no  Other

414. [ ] yes  [ ] no  Unknown

Specify diagnosis of liver toxicity by clinical signs and symptoms / evaluation:

- [ ] Ascites
- [ ] Autopsy
- [ ] Bilirubin > 2.0 mg
- [ ] Biopsy
- [ ] Elevated hepatic venous pressure gradient
- [ ] Elevated liver enzymes (e.g., alkaline phosphatase, ALT, AST, LDH, GGT)
- [ ] Hepatomegaly
- [ ] Right upper quadrant pain or tenderness
- [ ] Ultrasonography / doppler (abnormal portal vein flow)
- [ ] Weight gain > 5%

413. Specify other etiology: ____________________________

### Other Organ Impairment / Disorder

427. Has the recipient developed any other clinically significant organ impairment or disorder since the date of the last report?

- [ ] yes
- [x] no

Specify impairment / disorder:

428. [ ] yes  [ ] no  Avascular necrosis

430. [ ] yes  [ ] no  Cataracts

432. [ ] yes  [ ] no  Congestive heart failure (EF < 40%)

434. [ ] yes  [ ] no  Diabetes / hyperglycemia

436. [ ] yes  [ ] no  Gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)

438. [ ] yes  [ ] no  Growth hormone deficiency / growth disturbance

440. [ ] yes  [ ] no  Hemorrhagic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transusions, urology consult)

- [ ] yes
- [ ] no

Specify impairment / disorder:

- [ ] no

Date of diagnosis: [ ] [ ] [ ]
New Malignancy

459. Did a new malignancy, lymphoproliferative or myeloproliferative disorder develop since the date of the last report that is different from the disease for which the HSCT was performed?
1  o yes  
2  o no

460. For all new malignancies except for "other skin malignancy (basal cell, squamous)," was testing performed to determine the cell of origin?
1  o yes  
2  o no

Specify the cell origin of the new malignancy:
1  o recipient (host)
2  o donor
3  o origin unknown

461. Specify the cell origin of the new malignancy:

462. Is a copy of the cell origin evaluation (VNTR, cytogenetics, FISH) attached?
1  o yes  
2  o no

Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 462 on the report.

Specify which new disease(s) occurred:
463. 1  o yes  2  o no Acute myeloid leukemia (AML / ANLL)
465. 1  o yes  2  o no Other leukemia, including ALL

Date of diagnosis:
Month  Day  Year

467. Specify other leukemia:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>468.</td>
<td>Breast cancer</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>470.</td>
<td>Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>472.</td>
<td>Clonal cytogenetic abnormality without leukemia or MDS</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>474.</td>
<td>Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>476.</td>
<td>Genitourinary malignancy (kidney, bladder, ovary, testicle genitalia, uterus, cervix)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>478.</td>
<td>Hodgkin disease</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>480.</td>
<td>Lung cancer</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>482.</td>
<td>Lymphoma or lymphoproliferative disease</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>485.</td>
<td>Melanoma</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>487.</td>
<td>Other skin malignancy (basal cell, squamous)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>490.</td>
<td>Myelodysplasia (MDS) / myeloproliferative (MPS) disorder</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>492.</td>
<td>Oropharyngeal cancer (tongue, buccal mucosa)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>494.</td>
<td>Sarcoma</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>496.</td>
<td>Thyroid cancer</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>498.</td>
<td>Other new malignancy</td>
<td>yes 2 no</td>
</tr>
</tbody>
</table>

501. Is a pathology / autopsy report or other documentation attached?

1 yes 2 no

Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 501 on the report.
Survival and Functional Status

502. Specify the functional status of the recipient on the date of last actual contact (table below). If the recipient has died, continue with question 505.

If the recipient is 16 years of age or older, complete the Karnofsky Scale. If the recipient is younger than 16 years of age, complete the Lansky Scale.

**Karnofsky Scale (recipient age ≥ 16 years)**

Select the phrase in the Karnofsky Scale which best describes the activity status of the recipient:

- Able to carry on normal activity; no special care is needed
- 100 Normal; no complaints; no evidence of disease
- 90 Able to carry on normal activity
- 80 Normal activity with effort
- Unable to work; able to live at home, cares for most personal needs; a varying amount of assistance is needed
- 70 Care for self; unable to carry on normal activity or to do active work
- 60 Requires occasional assistance but is able to care for most needs
- 50 Requires considerable assistance and frequent medical care
- Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly
- 40 Disabled; requires special care and assistance
- 30 Severely disabled; hospitalization indicated, although death not imminent
- 20 Very sick; hospitalization necessary
- 10 Moribund; fatal process progressing rapidly

**Lansky Scale (recipient age < 16 years)**

Select the phrase in the Lansky Play-Performance Scale which best describes the activity status of the recipient:

- Able to carry on normal activity; no special care is needed
- 100 Fully active
- 90 Minor restriction in physically strenuous play
- 80 Restricted in strenuous play, tires more easily, otherwise active
- Mild to moderate restriction
- 70 Both greater restrictions of, and less time spent in, active play
- 60 Ambulatory up to 50% of time, limited active play with assistance / supervision
- 50 Considerable assistance required for any active play; fully able to engage in quiet play
- Moderate to severe restriction
- 40 Able to initiate quiet activities
- 30 Needs considerable assistance for quiet activity
- 20 Limited to very passive activity initiated by others (e.g., TV)
- 10 Completely disabled, not even passive play

503. Specify the category which best describes the recipient’s current occupation. If the recipient is not currently employed, check the box which best describes his/her last job:

- 1 professional, technical, or related occupation (e.g., teacher/professor, nurse/physician, lawyer, engineer)
- 2 manager, administrator, or proprietor (e.g., sales manager, real estate agent, postmaster)
- 3 clerical or related occupation (e.g., secretary, clerk, mail carrier)
- 4 sales occupation (e.g., sales associate, demonstrator, agent, broker)
- 5 service occupation (e.g., police officer, cook, hairdresser)
- 6 skilled craft or related occupation (e.g., carpenter, repair technician, telephone line worker)
- 7 equipment / vehicle operator or related occupation (e.g., driver, railroad brakeman, sewer worker)
- 8 laborer (e.g., helper, longshoreman, warehouse worker)
- 9 farmer (e.g., owner, manager, operator, tenant)
- 10 member of the military
- 11 homemaker
- 12 student
- 13 under school age
- 14 not previously employed
- 15 unknown
- 16 other

Continue with question 507

504. Specify other occupation:

505. What is the recipient’s current or most recent work status during this reporting period?

- 1 full time
- 2 part time
- 3 unemployed
- 4 medical disability
- 5 retired
- 6 recipient < 16 years old
- 7 unknown

506. Specify retirement status:

- 1 with a source of income
- 2 no source of income
Subsequent HSCT

Complete this section if the recipient received a subsequent HSCT (question 2, answered “yes”). If no subsequent HSCTs were performed, continue with the DCI section at question 515.

507. Date of subsequent HSCT:

508. Was the subsequent HSCT performed at a different institution?

1. yes
2. no

509. Specify the institution that performed the subsequent HSCT:

Name: __________________________
City: __________________________
State / Country: _______________________

510. What was the indication for subsequent HSCT?

Subsequent autologous HSCTs performed for engraftment reasons (options 1–3) do not require separate report forms to be completed. All other subsequent HSCTs will require a separate follow-up report form completed for each infusion.

1. no hematopoietic recovery
2. partial hematopoietic recovery
3. graft failure / rejection after achieving initial hematopoietic recovery
4. persistent primary disease
5. recurrent primary disease
6. planned second HSCT, per protocol
7. new malignancy
8. stable, mixed chimerism
9. declining chimerism
10. other

511. Specify other indication: __________________________

512. Source of HSCs:

If more than one product is infused, copy and complete questions 512–514 for each product.

1. allogeneic, related

Complete a new Form 2000 — Recipient Baseline Data.

513. Was the same donor used?

1. yes
2. no

2. allogeneic, unrelated

Complete a new Form 2000 — Recipient Baseline Data.

514. Specify:

1. fresh, original NMDP donor bone marrow
2. fresh, original non-NMDP donor bone marrow
3. fresh, new NMDP donor bone marrow
4. fresh, new non-NMDP donor bone marrow
5. fresh, original NMDP donor mobilized peripheral blood stem cells
6. fresh, original non-NMDP donor mobilized peripheral blood stem cells
7. fresh, new NMDP donor mobilized peripheral blood stem cells
8. fresh, new non-NMDP donor mobilized peripheral blood stem cells
9. NMDP cord blood
10. non-NMDP cord blood
11. cryopreserved original donor bone marrow
12. cryopreserved original donor mobilized peripheral blood stem cells

3. autologous

Complete a new Form 2000 — Recipient Baseline Data.
Donor Cellular Infusion (DCI) Information

This section captures information on DCIs (question 4, answered “yes”) from any donor source (unstimulated peripheral blood mononuclear cells, T cells, NK cells, other cells). Complete this DCI section for all infusions given in a 10 week period. If more than 10 weeks have elapsed between DCIs, copy and complete this section for each 10 week period. If the recipient did not receive any DCIs, continue with the signature lines at question 614.

515. Date the first DCI was given: ___________ ___________ ___________

516. Specify the total number of cell infusions given within 10 weeks of the first DCI: ___________

517. Was the DCI infusion performed at a different institution?
   1. yes
   2. no

518. Specify the institution that performed the DCI:
   Name: __________________________
   City: __________________________
   State / Country: __________________

519. Indication for DCI:
   1. planned as part of initial HSCT protocol
   2. treatment for relapsed, persistent or progressive disease
   3. treatment for B cell lympho-proliferative disorder (PTLD, EBV lymphoma)
   4. treatment for GVHD
   5. viral infection
   6. stable, mixed chimerism
   7. loss of / decreased donor T-cell chimerism
   8. other

Specify the method(s) of disease detection below. For each method used, if the result was positive report the first date the disease was detected; if the result was negative report the last date the method was used prior to DCI (question 515).

520. 1. molecular 2. cytogenetic 3. clinical evidence / hematologic

521. Date: ___________ ___________ ___________

522. Date: ___________ ___________ ___________

523. Date: ___________ ___________ ___________

524. Date: ___________ ___________ ___________

525. Date: ___________ ___________ ___________

526. Was chemotherapy used to attempt to induce disease response prior to the first DCI?
   1. yes
   2. no

527. Date of administration of final chemotherapy dose: ___________ ___________ ___________

528. Specify viral organism code: (see page 14 for code list)

529. Date documented: (document chimerism testing on page 5 or 6)

530. Specify other indication: ___________________________________________________________________

531. What was the recipient’s disease status immediately prior to the first DCI?
   1. first complete remission post-HSCT (no hematologic evidence of disease)
   2. therapy-induced complete remission after persistent disease or relapse post-HSCT
   3. relapse or progression
   4. persistent disease
   5. not evaluated post-HSCT

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Internal use: Document number F00483 revision 2 Replaces: F00483 version 1.0 July 2007

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
<table>
<thead>
<tr>
<th>CIBMTR Recipient ID:</th>
<th>CIBMTR Center Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

532. Date disease status was established prior to the first DCI: [ ] [ ] [ ]

533. Specify the functional status of the recipient immediately prior to the first DCI: [ ]

(see page 20 for Karnofsky / Lansky Scale descriptions)

Specify DCI source:

534. [ ] yes  [ ] no Collected at the time of PBSC mobilization and collection

535. [ ] yes  [ ] no Negative fraction of CD34 selected PBSC

536. [ ] yes  [ ] no Negative fraction of CD34 selected bone marrow

537. [ ] yes  [ ] no Apheresis at a different time than collection of PBSC used for allogeneic HSCT

538. Date of apheresis: [ ] [ ] [ ]

539. [ ] yes  [ ] no Isolated from a unit(s) of whole blood

540. Specify number of units: [ ]

541. Were the donor cells collected by leukapheresis?

[ ] yes  [ ] no

542. Date of first leukapheresis: [ ] [ ] [ ]

543. Date of last leukapheresis: [ ] [ ] [ ]

544. Number of leukaphereses: [ ]

545. Did the donor receive treatment to enhance cell collection prior to donation?

[ ] yes  [ ] no

Specify treatment(s) given:

546. Growth factors

547. [ ] yes  [ ] no G-CSF

548. [ ] yes  [ ] no GM-CSF

549. [ ] yes  [ ] no Other agent

550. Specify other agent: [ ]

551. Other treatment

552. Specify other treatment: [ ]

For each DCI given, report the total number of cells infused. If the cells were cryopreserved, report the totals after processing, but before cryopreservation. Copy this page to report more than one infusion.

<table>
<thead>
<tr>
<th>Total cells:</th>
<th>Specify exponent: [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD3+ cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>CD4+ cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>CD8+ cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>CD34+ cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>NK cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>Nucleated cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
<tr>
<td>Mesenchymal cells:</td>
<td>x 10 [ ] [ ] [ ] [ ] not tested</td>
</tr>
</tbody>
</table>
560. Were dendritic cells infused?  
   1 ☐ yes  
   2 ☐ no

561. Were fibroblasts infused?  
   1 ☐ yes  
   2 ☐ no

562. Were any other cell types infused (not including cell types reported in questions 553–559)?  
   1 ☐ yes  
   2 ☐ no

564. Were the cells cryopreserved prior to infusion?  
   1 ☐ yes  
   2 ☐ no

566. Were the cells manipulated prior to infusion?  
   1 ☐ yes  
   2 ☐ no

Specify all methods used to manipulate the cells:

567. Specify portion manipulated:  
   1 ☐ all cells  
   2 ☐ portion of cells

568. ABO incompatibility  

   1 ☐ yes  
   2 ☐ no

Specify method:

   569. 1 ☐ yes  
         2 ☐ no  Buffy coat preparation
   570. 1 ☐ yes  
         2 ☐ no  Cell separator (i.e., COBE Spectra)
   571. 1 ☐ yes  
         2 ☐ no  Density gradient separation (i.e., Ficoll)
   572. 1 ☐ yes  
         2 ☐ no  Plasma removal
   573. 1 ☐ yes  
         2 ☐ no  Sedimentation (i.e., hetastarch)
   574. 1 ☐ yes  
         2 ☐ no  Other  

575. Specify other method:

576. ☐ 1 yes  
      2 ☐ no  Dextran-albumin wash

577. ☐ 1 yes  
      2 ☐ no  Ex-vivo expansion

578. ☐ 1 yes  
      2 ☐ no  Genetic manipulation (gene transfer / transduction)

579. ☐ 1 yes  
      2 ☐ no  Volume reduction

580. CD34+ selection  

   1 ☐ yes  
   2 ☐ no

581. Specify manufacturer:  
   1 ☐ CliniMACS / CliniMax
   2 ☐ Isolex
   3 ☐ Other  

582. Specify other manufacturer:

583. T-cell depletion  

   1 ☐ yes  
   2 ☐ no

Specify method:

   584. 1 ☐ yes  
         2 ☐ no  Antibody affinity column
   585. 1 ☐ yes  
         2 ☐ no  Antibody coated plates
   586. 1 ☐ yes  
         2 ☐ no  Antibody coated plates and soybean lectin
   587. 1 ☐ yes  
         2 ☐ no  Antibody + complement
   588. 1 ☐ yes  
         2 ☐ no  Antibody + toxin
   589. 1 ☐ yes  
         2 ☐ no  Immunomagnetic beads
   590. 1 ☐ yes  
         2 ☐ no  Elutriation
   591. 1 ☐ yes  
         2 ☐ no  CD34 affinity column plus sheep red blood cell rosetting

592. ☐ 1 yes  
      2 ☐ no  Other  

593. Specify other method:

Report antibodies used for T-cell depletion at question 596.
ERROR CORRECTION FORM

CIBMTR Recipient ID: ____________________________
CIBMTR Center Number: ____________________________

Today's Date: ________/_______/______
Infusion Date: ________/_______/______

Month Day Year
Month Day Year

CIBMTR Center Number: ____________________________
CIBMTR Recipient ID: ____________________________

594. Other cell manipulation
1 yes
2 no

595. Specify other cell manipulation: ____________________________

596. Were antibodies used during graft manipulation?
1 yes
2 no

Specify antibodies:
597. 1 yes 2 no Anti CD2
598. 1 yes 2 no Anti CD4
599. 1 yes 2 no Anti CD5
600. 1 yes 2 no Anti CD6
601. 1 yes 2 no Anti CD7
602. 1 yes 2 no Anti CD8
603. 1 yes 2 no Anti CD34
604. 1 yes 2 no Anti TCR alpha / beta (T10-B9)
605. 1 yes 2 no OKT-3
606. 1 yes 2 no Other CD3

607. Specify other CD3: ____________________________

608. 1 yes 2 no Anti CD52

Specify antibodies:
609. 1 yes 2 no Campath-NOS
610. 1 yes 2 no Campath-1G
611. 1 yes 2 no Campath-1H

612. 1 yes 2 no Other antibody

613. Specify other antibody: ____________________________

614. Signed: __________________________________________

Person completing form

Please print name: ____________________________

Phone: (___________) ____________________________

Fax: (___________) ____________________________

E-mail address: ____________________________

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