**Form 2200 R3.0: Six Months to Two Years Post-HSCT Data**

**Center:**

**CIBMTR CRID:**

### Key Fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>Sequence Number:</td>
<td></td>
</tr>
<tr>
<td>Date Received:</td>
<td>__ __ __ __ - __ __- __ __</td>
</tr>
<tr>
<td>CIBMTR Center Number:</td>
<td></td>
</tr>
<tr>
<td>CIBMTR Recipient ID:</td>
<td></td>
</tr>
<tr>
<td>Today's Date:</td>
<td>__ __ __ __ - __ __- __ __</td>
</tr>
<tr>
<td>Date of HSCT for which this form is being completed:</td>
<td>__ __ __ __ - __ __- __ __</td>
</tr>
<tr>
<td>HSCT Type (check all that apply):</td>
<td></td>
</tr>
<tr>
<td>Autologous</td>
<td></td>
</tr>
<tr>
<td>Allogeneic, unrelated</td>
<td></td>
</tr>
<tr>
<td>Allogeneic, related</td>
<td></td>
</tr>
<tr>
<td>Syngeneic (identical twin)</td>
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</tr>
<tr>
<td>Product Type (check all that apply):</td>
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<tr>
<td>Marrow</td>
<td></td>
</tr>
<tr>
<td>PBSC</td>
<td></td>
</tr>
<tr>
<td>Cord blood</td>
<td></td>
</tr>
<tr>
<td>multiple cord blood units infused</td>
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</tr>
<tr>
<td>other product</td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td>Visit:</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>1 year</td>
</tr>
</tbody>
</table>

### Vital Status Questions: 1 - 4

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

2. **Did recipient receive a subsequent HSCT (bone marrow, mobilized peripheral blood stem cells, cord blood) since the date of contact from the last report?**
   - yes **Answers to subsequent questions should reflect clinical status immediately prior to the start of the preparative regimen for subsequent HSCT. Complete Subsequent HSCT questions 395-402.**
   - no

3. **Specify the recipient's survival status at the date of actual contact:**
   - Alive **Answers to subsequent questions should reflect clinical status between last day of contact reported on prior follow-up form and the day of actual contact for this follow-up form (question 1).**
   - Dead **Answers to subsequent questions should reflect clinical status between last day of contact reported on prior follow-up form and immediately prior to death. Complete a Form 2900 – Recipient Death Data.**

4. **Has the recipient received a donor cellular infusion (DCI) since the date of contact from the last report?**
   - yes **Complete DCI Information questions 403–501.**
   - no

---

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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

6 Date ANC >= 500/mm³ (first of 3 lab values): __ __ __ __

7 Following the initial hematopoietic recovery (ANC >= 500/mm³ for three consecutive lab values obtained on different days), did the recipient experience a subsequent decline in ANC to <500/mm³ for >= 3 days since the date of the last report?
   [ ] Yes
   [ ] No

8 Date of decline in ANC to < 500/mm³ for >= 3 days (first of 3 days that the ANC declined): __ __ __ __

Actual CBC on first day of decline:

9 WBC: ___________________________ x 10⁹/L (x 10⁹/mm³)
   [ ] x 10⁹/L

10 Neutrophils: _____________________ %

11 Did recipient recover and maintain ANC >= 500/mm³ following the decline?
   [ ] Yes
   [ ] No

12 Date of ANC recovery: __.__.__.__.

CBC on first day of recovery:

13 WBC: ___________________________ x 10⁹/L (x 10⁹/mm³)
   [ ] x 10⁹/L

14 Neutrophils: _____________________ %
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 \( \geq 20 \times 10^9/\text{L} \) achieved since the date of the last report?

- Yes
- No

if no, platelet count never dropped below \( 20 \times 10^9/\text{L} \)

\( \geq 20 \times 10^9/\text{L} \) was achieved and reported previously

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

- Date estimated
- Date unknown

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

- Yes
- No

if no, platelet count never dropped below \( 50 \times 10^9/\text{L} \)

\( \geq 50 \times 10^9/\text{L} \) was achieved and reported previously

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

- Date estimated
- Date unknown

---

### Current Hematologic Findings

Questions: 19 - 25

19 Date of most recent hematologic testing: __ __ __ __ - __ __ - __ __

20 WBC: ______________________________ \( \times 10^9/\text{L} \) (\( \times 10^9/\text{mm}^3 \))

\( \times 10^9/\text{L} \)

- Not tested

21 Neutrophils: ____________________ \%  Not tested

22 Lymphocytes: ____________________ \%  Not tested

23 Hemoglobin: ____________________ g/dL  g/L  mmol/L

- Not tested

- transfused RBC < 30 days from date of most current testing

24 Hematocrit: ____________________ \%  Not tested

- transfused RBC < 30 days from date of most current testing

25 Platelets: ____________________ \( \times 10^9/\text{L} \) (\( \times 10^9/\text{mm}^3 \))

\( \times 10^9/\text{L} \)

- Not tested

---

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Center: CRID:

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<th>Sequence Number:</th>
<th>CIBMTR Recipient ID:</th>
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<tbody>
<tr>
<td>Visit:</td>
<td></td>
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<tr>
<td>100 day</td>
<td></td>
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<tr>
<td>6 month</td>
<td></td>
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</tr>
<tr>
<td>0 year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Today’s Date:</td>
<td>Infusion Date:</td>
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</tr>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
</tr>
<tr>
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### Immune Reconstitution

**Questions: 26 - 47**

Transfused platelets < 7 days from date of most current testing

Specify the immunoglobulin values from the most recent testing:

<table>
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<tr>
<th>IgG:</th>
<th>mg/dL</th>
<th>g/dL</th>
<th>g/L</th>
</tr>
</thead>
<tbody>
<tr>
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Not tested

<table>
<thead>
<tr>
<th>IgM:</th>
<th>mg/dL</th>
<th>g/dL</th>
<th>g/L</th>
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<tbody>
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</tbody>
</table>

Not tested

<table>
<thead>
<tr>
<th>IgA:</th>
<th>mg/dL</th>
<th>g/dL</th>
<th>g/L</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Not tested

| 26 | IgG: | mg/dL | g/dL | g/L |
|    |      |       |      |     |

| 27 | Not tested |

| 28 | IgM: | mg/dL | g/dL | g/L |
|    |      |       |      |     |

| 29 | Not tested |

| 30 | IgA: | mg/dL | g/dL | g/L |
|    |      |       |      |     |

| 31 | Not tested |

| 32 | Did the recipient receive supplemental intravenous immunoglobulins (IVIG)(since the date of the last report)? |
|    | yes | no |

| 33 | Was therapy ongoing within one month of immunoglobulin testing? |
|    | yes | no |

**Indication(s) for use:**

| 34 | Prophylaxis for low IgG with no active infection (polyclonal IV gamma globulin / IVIG) |
|    | yes | no |

| 35 | Prophylaxis for cytomegalovirus (CMV) infection (CMV / hyperimmune gamma globulin) |
|    | yes | no |

| 36 | Treatment for CMV infection |
|    | yes | no |

| 37 | Treatment for respiratory syncytial virus (RSV) infection |
|    | yes | no |

| 38 | Treatment for infection with low IgG (not CMV or RSV) |
|    | yes | no |

| 39 | Other indication |
|    | yes | no |

| 40 | Specify other indication: |

| 41 | Were lymphocyte analyses performed since the date of the last report? |
|    | yes | no |
Date of most recent testing performed: __ __ __ __ - __ __- __ __

**CD3**

\[ \text{x } 10^{9} \text{L (x } 10^{3} \text{mm}^3) \]

\[ \text{x } 10^{9} \text{L} \]

Not tested

**CD4**

\[ \text{x } 10^{9} \text{L (x } 10^{3} \text{mm}^3) \]

\[ \text{x } 10^{9} \text{L} \]

Not tested

**CD8**

\[ \text{x } 10^{9} \text{L (x } 10^{3} \text{mm}^3) \]

\[ \text{x } 10^{9} \text{L} \]

Not tested

**CD20**

\[ \text{x } 10^{9} \text{L (x } 10^{3} \text{mm}^3) \]

\[ \text{x } 10^{9} \text{L} \]

Not tested

**CD56**

\[ \text{x } 10^{9} \text{L (x } 10^{3} \text{mm}^3) \]

\[ \text{x } 10^{9} \text{L} \]

Not tested

---

**Chimerism Studies**

Questions: 48 - 73

This section relates to chimerisms from allogeneic HSCTs only. If this was an autologous HSCT, continue with the Infection section at question 201.

48 **Allogeneic HSCTs only**: Were chimerism studies performed since the date of the last report?

- yes
- no

49 Are chimerism laboratory reports attached to this form?

- yes
- no

50 Were infusions from more than one donor given?

- yes
- no

51 Specify donor gender:

- male
- female

---

**Single Donor (1)**

Questions: 52 - 61

This section relates to chimerisms from allogeneic HSCTs only. If this was an autologous HSCT, continue with the Infection section at question 201.

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

52 Date __ __ __ __ - __ __- __ __
Multiple Donors (1) Questions: 62 - 73

This section relates to chimerisms from allogeneic HSCTs only. If this was an autologous HSCT, continue with the Infection section at question 201.

62 NMDP Donor ID: ____________________________
   -OR-
Donor / infant date of birth: __ __ __ __ - __ __- __ __
   -OR-
NMDP cord blood unit ID ____________________________
   -OR-
Non-NMDP unrelated donor ID: ____________________________
   -OR-
Non-NMDP cord blood unit ID: ____________________________

63 Donor / infant gender:
   in male  in female

64 Date __ __ __ __ - __ __- __ __

65 Method ____________________________

66 Specify: ____________________________

67 Cell type ____________________________

68 Specify: ____________________________

69 Total cells examined ____________________________

70 Number of donor cells ____________________________

71 Number of host cells ____________________________

72 Percent donor cells, quantitative ____________________________  Presence of donor cells was detected by non-quantitative method

73 Percent host cells, quantitative ____________________________  Presence of host cells was detected by non-quantitative method

Engraftment Syndrome Questions: 74 - 80

74 Did engraftment syndrome occur since the date of the last report?
   in yes  in no

75 Date of onset: __ __ __ __ - __ __- __ __
Specify symptoms of engraftment syndrome:

76 Capillary leak syndrome
   yes  no

77 Fever
   yes  no

78 Skin rash
   yes  no

79 Specify amount of body surface area affected: ____________%

80 Was engraftment syndrome treated with corticosteroids?
   yes  no

Acute Graft vs. Host Disease (GVHD)  Questions: 81 - 128

This section relates to graft-versus-host disease from allogeneic HSCTs only. If this was an autologous HSCT, continue with the Infection section at question 201.

81 Did acute GVHD develop or persist (or a flare-up that was more severe) since the date of the last report?
   yes  no  Unknown

82 Date of acute GVHD diagnosis: __ __ __ __ - __ __ - __ __ Date was previously reported

83 Was the diagnosis based on evidence from a biopsy (histology)?
   yes  no

Specify result(s):

84 gastrointestinal (GI)
   Positive  Negative  Inconclusive  Not tested

85 Liver
   Positive  Negative  Inconclusive  Not tested

86 Lung
   Positive  Negative  Inconclusive  Not tested

87 Skin
   Positive  Negative  Inconclusive  Not tested

88 Other site
   Positive  Negative  Inconclusive  Not tested

89 Specify other site: ________________________

90 Is a copy of the pathology report attached?
   yes  no

91 Was the diagnosis based on clinical evidence?
   yes  no
Maximum overall grade of acute GVHD:

I
II
III
IV

Is acute GVHD still present at the date of contact for this report (question 1)?

Yes
No
progressed to chronic GVHD
Unknown

List the maximum severity of organ involvement:

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

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

Upper intestinal tract:
stage 0 - no persistant nausea or vomiting
stage 1 - persistant nausea or vomiting
Liver

- no liver acute GVHD / bilirubin level not attributable to acute GVHD

- stage 0 – bilirubin < 2.0 mg/dL (< 34 µmol/L)
- stage 1 – bilirubin 2.0–3.0 mg/dL (34–52 µmol/L)
- stage 2 – bilirubin 3.1–6.0 mg/dL (53–103 µmol/L)
- stage 3 – bilirubin 6.1–15.0 mg/dL (104–256 µmol/L)
- stage 4 – bilirubin > 15.0 mg/dL (> 256 µmol/L)

Other clinical organ involvement?

- yes
- no

Specify site:

Lung

- yes
- no

Other site:

- yes
- no

Specify other site:

Was specific therapy used to treat acute GVHD since the date of the last report?

- yes
- no

Specify therapy administered to treat acute GVHD:

ALS, ALG, ATS, ATG

- yes
- no

Specify source:

- Horse
- Rabbit
- Other

Specify source:

Corticosteroids (systemic)

- yes
- no

Corticosteroids (topical)

- yes
- no

Cyclosporine (CSA) (Sandimmune, Neoral)

- yes
- no

ECP (extra-corporeal photopheresis)

- yes
- no
110 FK 506 (Tacrolimus, Prograf)
   yes  no

111 In vivo monoclonal antibody
   yes  no

Specify in vivo monoclonal antibody:

112 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
   yes  no

113 Specify anti CD25: ______________________

114 Campath
   yes  no

115 Etanercept (Enbrel)
   yes  no

116 Infliximab (Remicade)
   yes  no

117 Other in vivo monoclonal antibody
   yes  no

118 Specify antibody: ________________________

119 In vivo immunotoxin
   yes  no

120 Specify immunotoxin: _____________________

121 Methotrexate (MTX) (Amethopterin)
   yes  no

122 Mycophenolate mofetil (MMF) (CellCept)
   yes  no

123 Sirolimus (Rapamycin, Rapamune)
   yes  no

124 Ursodiol
   yes  no

125 Blinded randomized trial
   yes  no

126 Specify trial agent: ______________________

127 Other agent
   yes  no
128 Specify other agent: 

129 Did chronic GVHD develop or persist (or a flare-up that was more severe) since the date of the last report? 

Yes

No

No symptoms, but recipient is receiving treatment

Unknown

130 Date of chronic GVHD diagnosis: __ __ __ __ - __ __ __ __ Date was previously reported

131 Onset of chronic GVHD was:

Progressive (acute GVHD progressed directly to chronic GVHD)

Interrupted (acute GVHD resolved, then chronic GVHD developed)

De novo (acute GVHD never developed)

chronic GHVD flare (symptoms reactivated within 30 days of drug tapering or discontinuation)

132 Karnofsky / Lansky score at diagnosis of chronic GVHD:

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.

133 Platelet count at diagnosis of chronic GVHD: __ __ __ __ x 10^9/L (x 10^3/mm^3)

134 Diagnosis was based on:

histologic evidence / biopsy proven

Clinical evidence

Both

Unknown

135 Maximum grade of chronic GVHD:

limited – localized skin involvement and/or hepatic dysfunction due to chronic GVHD

disseminated – 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
Overall severity of chronic GVHD:
- **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)
- **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)
- **Severe** – signs and symptoms of chronic GVHD limit function substantially despite appropriate therapy or are progressive through second line therapy

### Organ Involvement

#### Sclerosis of skin
- **Yes**
- **No**

#### Other skin or hair involvement (rash, ulcers, pruritus or itching, dyspigmentation, alopecia, pruritus changes, etc.)
- **Yes**
- **No**

#### Eyes (xerophthalmia (dry eyes), abnormal Schirmer’s test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)
- **Yes**
- **No**

#### Mouth (lichenoid changes, mucositis / ulcers, erythema, etc.)
- **Yes**
- **No**

#### Bronchiolitis obliterans
- **Yes**
- **No**

#### Other lung involvement
- **Yes**
- **No**

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149 Gastrointestinal tract (esophageal involvement, chronic nausea / vomiting, chronic diarrhea, malabsorption, abdominal pain / cramps, etc.)
  yes
  no

150 Was involvement proven by biopsy?
  yes
  no

151 Liver
  yes
  no

152 Was involvement proven by biopsy?
  yes
  no

153 Genitourinary tract (vaginitis / stricture, etc.)
  yes
  no

154 Was involvement proven by biopsy?
  yes
  no

155 Musculoskeletal (arthritis, contractures, myositis, myasthenia, etc.)
  yes
  no

156 Was involvement proven by biopsy?
  yes
  no

157 Thrombocytopenia (< 100 x 10^9/L)
  yes
  no

158 Eosinophilia
  yes
  no

159 Autoantibodies
  yes
  no

160 Other hematologic involvement
  yes
  no

161 Serositis
  yes
  no

162 Was involvement proven by biopsy?
  yes
  no

163 Weight loss
  yes
  no

164 Other organ involvement from chronic GVHD
  yes
  no

165 Specify site: __________________________
166 Was involvement proven by biopsy?

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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167 Was specific therapy used to treat chronic GVHD?

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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</table>

Specify therapy:

168 ALS, ALG, ATS, ATG

<table>
<thead>
<tr>
<th></th>
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<th>no</th>
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</thead>
</table>

169 Specify source:

<table>
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<tr>
<th></th>
<th>Horse</th>
<th>Rabbit</th>
<th>Other</th>
</tr>
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170 Specify source: ________________________

171 Azathioprine

<table>
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<th></th>
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172 Corticosteroids (systemic)

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
</tr>
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173 Corticosteroids (topical)

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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174 Cyclosporine (CSA) (Sandimmune, Neoral)

<table>
<thead>
<tr>
<th></th>
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175 ECP (extracorporeal photopheresis)

<table>
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176 Etretinate

<table>
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177 FK 506 (Tacrolimus, Prograf)

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178 Hydroxychloroquine (Plaquenil)

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179 In vivo monoclonal antibody

<table>
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<tr>
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Specify:

180 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)

<table>
<thead>
<tr>
<th></th>
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181 Specify anti CD25: ________________________

182 Campath

<table>
<thead>
<tr>
<th></th>
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<th>no</th>
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<tbody>
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</tr>
<tr>
<td>183</td>
<td>Etanercept (Enbrel)</td>
<td>yes</td>
</tr>
<tr>
<td>184</td>
<td>Infliximab (Remicade)</td>
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</tr>
<tr>
<td>185</td>
<td>Other in vivo monoclonal antibody</td>
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<td>186</td>
<td>Specify antibody:</td>
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<td>187</td>
<td>Lamprene (Clofazimine)</td>
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<td>188</td>
<td>Mycophenolate mofetil (MMF) (CellCept)</td>
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</tr>
<tr>
<td>189</td>
<td>Pentostatin</td>
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</tr>
<tr>
<td>190</td>
<td>PUVA (Psoralen and UVA)</td>
<td>yes</td>
</tr>
<tr>
<td>191</td>
<td>Sirolimus (Rapamycin, Rapamune)</td>
<td>yes</td>
</tr>
<tr>
<td>192</td>
<td>Thalidomide</td>
<td>yes</td>
</tr>
<tr>
<td>193</td>
<td>Ursodiol</td>
<td>yes</td>
</tr>
<tr>
<td>194</td>
<td>Blinded randomized trial</td>
<td>yes</td>
</tr>
<tr>
<td>195</td>
<td>Specify trial agent:</td>
<td></td>
</tr>
<tr>
<td>196</td>
<td>Other agent:</td>
<td>yes</td>
</tr>
<tr>
<td>197</td>
<td>Specify other agent:</td>
<td></td>
</tr>
<tr>
<td>198</td>
<td>Are symptoms of chronic GVHD still present on the date of actual contact (or present at the time of death)?</td>
<td>yes</td>
</tr>
<tr>
<td>199</td>
<td>Is the recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD?</td>
<td>yes</td>
</tr>
<tr>
<td>200</td>
<td>Date final treatment administered:</td>
<td></td>
</tr>
</tbody>
</table>
### Infection

**201** Did the recipient receive any of the following agents for infection prophylaxis since the date of last report? (report prophylaxis immunoglobulins at questions 34-35)

<table>
<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify agent(s) given:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>202</strong> Systemic antibacterial antibiotics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>203</strong> Nonabsorbable oral antibiotics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>204</strong> Amphotericin (Fungizone) (non-lipid formulation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>205</strong> Amphotericin (e.g., Abelcet, AmBisome, Amphotec) (lipid formulation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>206</strong> Caspofungin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>207</strong> Fluconazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>208</strong> Itraconazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>209</strong> Micafungin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>210</strong> Posaconazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>211</strong> Ravuconazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>212</strong> Voriconazole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>213</strong> Other systemic antifungal agent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>214</strong> Specify other antifungal agent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>215</strong> Acyclovir</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>216</strong> Foscarnet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
177 Ganciclovir (DHPG)
  yes  no

178 Valganciclovir (Valcyte)
  yes  no

179 Valacyclovir
  yes  no

180 Other antiviral agent
  yes  no

217 Specify other antiviral agent: ____________________________

222 Atovaquone (Mepron)
  yes  no

223 Dapsone
  yes  no

224 Pentamidine inhaled
  yes  no

225 Pentamidine IV
  yes  no

226 Trimethoprim/sulfamethoxazole (Bactrim/Septra)
  yes  no

227 Other pneumocystis prophylaxis
  yes  no

228 Specify pneumocystis agent: ____________________________

229 Other prophylaxis agent
  yes  no

230 Specify other prophylaxis agent: _________________________

231 Did the recipient develop a clinically significant infection since the date of the last report?
  yes  no

Infection (1) Questions: 232 - 235

Report each infection organism, site and date of diagnosis.

232 Organism ____________________________

  If other, specify: ____________________________

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

234 Site ________________________________

235 Date of diagnosis: __ __ __ __ - __ __ - __ __

Mail, fax or email this form to Minneapolis. Fax: 612-527-5895. Email: scanform@ndmp.org. Retain the original form at the transplant center.
236 Did the recipient develop more than 7 infections post-HSCT?
   yes     no

237 Are extra pages attached?
   yes     no

Organ Function

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

238 Did the recipient develop interstitial pneumonitis (IPn or ARDS) / idiopathic pneumonia syndrome (IPS) since the date of the last report?
   yes     no

Pulmonary function (1)

239 Date of diagnosis of IPn / IPS: __ __ __ __ - __ __ __ __

240 Were diagnostic tests done (other than radiographic studies)?
   yes     no

   Diagnosis was evaluated by:

241 bronchoalveolar lavage (BAL)
   yes     no

242 transbronchial biopsy
   yes     no

243 open / thorascopic (VATS) lung biopsy
   yes     no

244 autopsy
   yes     no

245 Other test
   yes     no

246 Specify other test: ________________________________

247 Was an organism isolated?
   yes     no / idiopathic

Etiology:

248 adenovirus
   yes     no

249 cytomegalovirus (CMV)
   yes     no

250 herpes simplex (HSV1, HSV2)
   yes     no
251 human herpes virus type 6 (HHV6)
   yes  no

252 parainfluenza
   yes  no

253 respiratory syncytial virus (RSV)
   yes  no

254 toxoplasma
   yes  no

255 other virus
   yes  no

256 Specify other virus: ____________________________

257 other organism
   yes  no

258 Specify organism: ____________________________

259 Did the recipient experience two or more episodes of IPn / IPS since the date of the last report?
   yes  no

260 Are extra pages attached?
   yes  no

261 Did the recipient develop non-infectious pulmonary abnormalities (other than IPn / IPS / ARDS) since the date of the last report?
   yes  no

262 Did the recipient develop bronchiolitis obliterans after the start of preparative regimen to date of last contact (question 1)?
   yes  no

263 Date of diagnosis: __ __ __ __ - __ __ __

264 Were diagnostic tests done?
   yes  no

Diagnosis was evaluated by:

265 bronchoalveolar lavage (BAL)
   yes  no

266 transbronchial biopsy
   yes  no

267 open / thorascopic (VATS) lung biopsy
   yes  no
268 autopsy
   yes [ ] no [ ]

269 Other
   yes [ ] no [ ]

270 Specify: ____________________________

271 Did the recipient develop pulmonary hemorrhage?
   yes [ ] no [ ]

272 Date of diagnosis: __ __ __ __ - __ __ __

273 Were diagnostic tests done?
   yes [ ] no [ ]

Diagnosis was evaluated by:

274 bronchoalveolar lavage (BAL)
   yes [ ] no [ ]

275 transbronchial biopsy
   yes [ ] no [ ]

276 open / thorascopic (VATS) lung biopsy
   yes [ ] no [ ]

277 autopsy
   yes [ ] no [ ]

278 Other
   yes [ ] no [ ]

279 Specify: ____________________________

280 Did the recipient develop cryptogenic organizing pneumonia (COP)?
   yes [ ] no [ ]

281 Date of diagnosis: __ __ __ __ - __ __ __

282 Were diagnostic tests done?
   yes [ ] no [ ]

Diagnosis was evaluated by:

283 bronchoalveolar lavage (BAL)
   yes [ ] no [ ]

284 transbronchial biopsy
   yes [ ] no [ ]

285 open / thorascopic (VATS) lung biopsy
   yes [ ] no [ ]
286 autopsy

   yes  no

287 Other

   yes  no

288 Specify: ____________________________

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

   yes  no

290 Specify other pulmonary abnormality: ____________________________

291 Did the recipient receive endotracheal intubation or mechanical ventilation post-HSCT?

   yes  no

Liver Function

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

   yes  no

293 Date of diagnosis: __ __ __ __ - __ __ __ __

Etiology:

294 cirrhosis

   yes  no

295 veno-occlusive disease (VOD) / sinusodial obstruction syndrome (SOS)

   yes  no

296 Did the recipient receive treatment for VOD?

   yes  no

297 Specify: ____________________________

298 Did VOD resolve?

   yes  no

299 Maximum bilirubin since last report: ____________________________

300 Other

   yes  no

301 Specify other etiology: ____________________________

302 Unknown

   yes  no

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

303 ascites

   yes  no

304 autopsy

   yes  no
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<thead>
<tr>
<th>305</th>
<th>bilirubin &gt; 2.0 mg</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
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<td></td>
<td>no</td>
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</table>

<table>
<thead>
<tr>
<th>306</th>
<th>biopsy</th>
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<tbody>
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<td></td>
<td>yes</td>
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<tr>
<td></td>
<td>no</td>
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</table>

<table>
<thead>
<tr>
<th>307</th>
<th>elevated hepatic venous pressure gradient</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>308</th>
<th>elevated liver enzymes (e.g., alkaline phosphatase, ALT, AST, LDH, GGT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>309</th>
<th>hepatomegaly</th>
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<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>310</th>
<th>right upper quadrant pain or tenderness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>311</th>
<th>ultrasonography / doppler (abnormal portal vein flow)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>312</th>
<th>weight gain &gt; 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
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</table>

<table>
<thead>
<tr>
<th>313</th>
<th>Other</th>
</tr>
</thead>
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<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>314</th>
<th>Specify other evaluation: __________________________</th>
</tr>
</thead>
</table>

### Other Organ Impairment / Disorder

<table>
<thead>
<tr>
<th>315</th>
<th>Has the recipient developed any other clinically significant organ impairment or disorder since the date of the last report?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Specify impairment / disorder:**

<table>
<thead>
<tr>
<th>316</th>
<th>avascular necrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>317</th>
<th>cataracts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>318</th>
<th>congestive heart failure (EF &lt; 40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>319</th>
<th>diabetes / hyperglycemia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>320</th>
<th>congestive heart failure (EF &lt; 40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>321</th>
<th>diabetes / hyperglycemia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __-

<table>
<thead>
<tr>
<th>322</th>
<th>diabetes / hyperglycemia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
</tbody>
</table>

**Date of diagnosis:** __ __ __ __ - __ __

---

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.
324 gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)

325 Date of diagnosis: __ __ __ __ - __ __ - __ __

326 growth hormone deficiency / growth disturbance

327 Date of diagnosis: __ __ __ __ - __ __ - __ __

328 hemorraghic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transfusions, urology consult)

329 Date of diagnosis: __ __ __ __ - __ __ - __ __

330 hypothyroidism

331 Date of diagnosis: __ __ __ __ - __ __ - __ __

332 myocardial infarction

333 Date of diagnosis: __ __ __ __ - __ __ - __ __

334 pancreatitis

335 Date of diagnosis: __ __ __ __ - __ __ - __ __

336 post-transplant microangiopathy-thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS), or similar syndrome

337 Date of diagnosis: __ __ __ __ - __ __ - __ __

338 Did the recipient receive plasmapheresis?

339 renal failure severe enough to warrant dialysis

340 Date of diagnosis: __ __ __ __ - __ __ - __ __

341 Did the recipient receive dialysis?

342 stroke / seizure

343 Date of diagnosis: __ __ __ __ - __ __ - __ __

344 Other impairment or disorder

345 Date of diagnosis: __ __ __ __ - __ __ - __ __

346 Specify other impairment / disorder: _____________________________
**New Malignancy**

347 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?

- [ ] yes
- [ ] no

348 For all new malignancies except for "other skin malignancy (basal cell, squamous)," was testing performed to determine the cell of origin?

- [ ] Yes
- [ ] No

349 Specify the cell origin of the new malignancy:

- [ ] recipient (host)
- [ ] donor
- [ ] origin unknown

350 Is a copy of the cell origin evaluation (VNTR, cytogenetics, FISH) attached?

- [ ] yes
  - Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 350 on the report.
- [ ] no

Specify which new disease(s) occurred:

351 Acute myeloid leukemia (AML / ANLL)

- [ ] yes
- [ ] no

352 Date of diagnosis: ______-____-____

353 Other leukemia, including ALL

- [ ] yes
- [ ] no

354 Date of diagnosis: ______-____-____

355 Specify other leukemia: ____________________________

356 Breast cancer

- [ ] yes
- [ ] no

357 Date of diagnosis: ______-____-____

358 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

- [ ] yes
- [ ] no

359 Date of diagnosis: ______-____-____

360 Clonal cytogenetic abnormality without leukemia or MDS

- [ ] yes
- [ ] no

361 Date of diagnosis: ______-____-____

362 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

- [ ] yes
- [ ] no

363 Date of diagnosis: ______-____-____
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>364</td>
<td>Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>365</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>366</td>
<td>Hodgkin disease</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>367</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>368</td>
<td>Lung cancer</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>369</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>370</td>
<td>Lymphoma or lymphoproliferative disease</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>371</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>372</td>
<td>Is the tumor EBV positive?</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>373</td>
<td>Melanoma</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
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<tr>
<td>374</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>375</td>
<td>Other skin malignancy (basal cell, squamous)</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>376</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>377</td>
<td>Specify other skin malignancy:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>378</td>
<td>Myelodysplasia (MDS) / myeloproliferative (MPS) disorder</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>379</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>380</td>
<td>Oropharyngeal cancer (tongue, buccal mucosa)</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>381</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>382</td>
<td>Sarcoma</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
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<tr>
<td>383</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>384</td>
<td>Thyroid cancer</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
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<tr>
<td>385</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>386</td>
<td>Other new malignancy</td>
<td></td>
<td>yes</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>387</td>
<td>Date of diagnosis:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Form 2200 R3.0: Six Months to Two Years Post-HSCT Data**
388 Specify other new malignancy: ____________________________

389 Is a pathology / autopsy report or other documentation attached?

Yes Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 389 on the report.

No

Survival and Functional Status

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.

390 Which scale was used, Karnofsky or Lansky? Specify the functional status of the recipient on the date of last actual contact.

Karnofsky [ ] Lansky [ ]

391 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:

Professional, technical, or related occupation [ ]
Manager, administrator, or proprietor [ ]
Clerical or related occupation [ ]
Sales occupation [ ]
Service occupation [ ]
Skilled craft or related occupation [ ]
Equipment / vehicle operator or related occupation [ ]
Laborer [ ]
Farmer [ ]
Member of the military [ ]
Homemaker [ ]
Student [ ]
Under school age [ ]
Not previously employed [ ]
Unknown [ ]
Other [ ]

392 Specify other occupation: ____________________________
Form 2200 R3.0: Six Months to Two Years Post-HSCT Data

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>393</td>
<td>What is the recipient's current or most recent work status during this reporting period?</td>
</tr>
<tr>
<td></td>
<td>full time</td>
</tr>
<tr>
<td></td>
<td>part time</td>
</tr>
<tr>
<td></td>
<td>unemployed</td>
</tr>
<tr>
<td></td>
<td>medical disability</td>
</tr>
<tr>
<td></td>
<td>retired</td>
</tr>
<tr>
<td></td>
<td>recipient &lt; 16 years old</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>394</td>
<td>Specify retirement status:</td>
</tr>
<tr>
<td></td>
<td>with a source of income</td>
</tr>
<tr>
<td></td>
<td>no source of income</td>
</tr>
</tbody>
</table>

**Subsequent HSCT/DCI Questions: 395 - 501**

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 403.

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>395</td>
<td>Date of subsequent HSCT: __ __ __ __ __ __</td>
</tr>
<tr>
<td>396</td>
<td>Was the subsequent HSCT performed at a different institution?</td>
</tr>
<tr>
<td></td>
<td>yes</td>
</tr>
<tr>
<td></td>
<td>no</td>
</tr>
<tr>
<td>397</td>
<td>Name: __________________________</td>
</tr>
<tr>
<td></td>
<td>City: __________________________ State / Country: __________________________</td>
</tr>
<tr>
<td>398</td>
<td>What was the indication for subsequent HSCT?</td>
</tr>
<tr>
<td></td>
<td>no hematopoietic recovery</td>
</tr>
<tr>
<td></td>
<td>partial hematopoietic recovery</td>
</tr>
<tr>
<td></td>
<td>graft failure / rejection after achieving initial hematopoietic recovery</td>
</tr>
<tr>
<td></td>
<td>persistent primary disease</td>
</tr>
<tr>
<td></td>
<td>recurrent primary disease</td>
</tr>
<tr>
<td></td>
<td>Planned second HSCT, per protocol</td>
</tr>
<tr>
<td></td>
<td>new malignancy</td>
</tr>
<tr>
<td></td>
<td>stable, mixed chimerism</td>
</tr>
<tr>
<td></td>
<td>declining chimerism</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

**HSCT Multiple Source (1) Questions: 400 - 402**
Donor Cellular Infusion (DCI) Information (1)

This section captures information on DCIs (question 7, 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 502.

403 Date the first DCI was given: __ __ __ __ - __ __ __ __

404 Specify the number of cell infusions given within 10 weeks of the first DCI:

405 Was the DCI infusion performed at a different institution?

   yes  no

406 Name: __________________________

   City: __________________________ State / Country: __________________________
**Form 2200 R3.0: Six Months to Two Years Post-HSCT Data**

**Center:**

**CRID:**

### 407 Indication for DCI:
- planned as part of initial HSCT protocol
- treatment for relapsed, persistent or progressive disease
- treatment for B cell lympho-proliferative disorder (PTLD, EBV lymphoma)
- treatment for GVHD
- viral infection
- stable, mixed chimerism
- loss of / decreased donor T-cell chimerism
- 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 403).

#### 408 Molecular
- Positive
- Negative
- not done / unknown

#### 409 Date: __ __ __ __ - __ __ - __ __

#### 410 Cytogenetic
- Positive
- Negative
- not done / unknown

#### 411 Date: __ __ __ __ - __ __ - __ __

#### 412 clinical evidence / hematologic
- Positive
- Negative
- not done / unknown

#### 413 Date: __ __ __ __ - __ __ - __ __

#### 414 Was chemotherapy used to attempt to induce disease response prior to the first DCI?
- yes
- no

#### 415 Date of administration of final chemotherapy dose: __ __ __ __ - __ __ - __ __

#### 416 Specify viral organism code: ______________________

#### 417 Date documented: __ __ __ __ - __ __ - __ __

#### 418 Specify other indication: ______________________

#### 419 What was the recipient's disease status immediately prior to the first DCI?
- first complete remission post-HSCT (no hematologic evidence of disease)
- therapy-induced complete remission after persistent disease or relapse post-HSCT
- Relapse or progression
- Persistent disease
- not evaluated post-HSCT

#### 420 Date disease status was established prior to the first DCI: __ __ __ __ - __ __ - __ __
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.

421 Specify the functional status of the recipient immediately prior to the first DCI: ____________________________

 Specify DCI source:

422 collected at the time of PBSC mobilization and collection

| yes | no |

423 negative fraction of CD34 selected PBSC

| yes | no |

424 negative fraction of CD34 selected bone marrow

| yes | no |

425 apheresis at a different time than collection of PBSC used for allogeneic HSCT

| yes | no |

426 Date of Apheresis: __ __ __ __ - __ __

427 isolated from a unit(s) of whole blood

| yes | no |

428 Specify number of units: ____________________________

429 Were the donor cells collected by leukapheresis?

| yes | no |

430 Date of first leukapheresis: __ __ __ __ - __ __

431 Date of last leukapheresis: __ __ __ __ - __ __

432 Number of leukaphereses: ____________________________

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

| yes | no |

 Specify treatment(s) given:

434 Growth factors

| yes | no |

 Specify agent:

435 G-CSF

| yes | no |

436 GM-CSF

| yes | no |

437 Other agent

| yes | no |

438 Specify other agent: ____________________________

439 Other treatment

| yes | no |

440 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.

441 CD3+ cells: __________ x10 Specify exponent: __________
442 CD4+ cells: __________ x10 Specify exponent: __________
443 CD8+ cells: __________ x10 Specify exponent: __________
444 CD34+ cells: __________ x10 Specify exponent: __________
445 NK cells: __________ x10 Specify exponent: __________
446 Nucleated cells: __________ x10 Specify exponent: __________
447 Mesenchymal cells: __________ x10 Specify exponent: __________

448 Were dendritic cells infused? [ ] yes [ ] no

449 Were fibroblasts infused? [ ] yes [ ] no

450 Were any other cell types infused? [ ] yes [ ] no (Not including cell types reported in questions 441-449)

451 Specify other cell type(s): _________________________

452 Were the cells cryopreserved prior to infusion? [ ] yes [ ] no

453 Specify portion cryopreserved: [ ] all cells [ ] portion of cells

454 Were the cells manipulated prior to infusion? [ ] yes [ ] no

455 Specify portion manipulated: [ ] all cells [ ] portion of cells

Specify all methods used to manipulate the cells:

456 ABO incompatibility [ ] yes [ ] no
Specify method:

457 buffy coat preparation
   yes  no

458 cell separator (i.e., COBE Spectra)
   yes  no

459 density gradient separation (i.e., Ficoll)
   yes  no

460 plasma removal
   yes  no

461 sedimentation (i.e., hetastarch)
   yes  no

462 other
   yes  no

463 Specify other method: __________________________

464 dextran-albumin wash
   yes  no

465 ex-vivo expansion
   yes  no

466 genetic manipulation (gene transfer / transduction)
   yes  no

467 volume reduction
   yes  no

468 CD34+ selection
   yes  no

469 Specify manufacturer:
   ClinIMACS / CliniMax  Isolex  Other

470 Specify other manufacturer: __________________________

471 T-cell depletion
   yes  no

Specify method:

472 Antibody affinity column
   yes  Report antibodies used for T-cell depletion at question 484.
   no
<table>
<thead>
<tr>
<th>Question No.</th>
<th>Method Description</th>
<th>Yes/No</th>
<th>Description</th>
</tr>
</thead>
</table>
| 473         | Antibody coated plates | yes | Report antibodies used for T-cell depletion at question 484.  
no | |
| 474         | Antibody coated plates and soybean lectin | yes | Report antibodies used for T-cell depletion at question 484.  
no | |
| 475         | Antibody + complement | yes | Report antibodies used for T-cell depletion at question 484.  
no | |
| 476         | Antibody + toxin | yes | -Report antibodies used for T-cell depletion at question 484.  
no | |
| 477         | Immunomagnetic beads | yes | Report antibodies used for T-cell depletion at question 484.  
no | |
| 478         | Elutriation | yes |  
no | |
| 479         | CD34 affinity column plus sheep red blood cell rosetting | yes |  
no | |
| 480         | Other | yes |  
no | |
| 481         | Specify other method: |  |  
| 482         | Other cell manipulation | yes |  
no | |
| 483         | Specify other cell manipulation: |  |  
| 484         | Were antibodies used during graft manipulation? | yes |  
no | |
| 485         | Anti CD2 | yes |  
no | |
| 486         | Anti CD4 | yes |  
no | |
Form 2200 R3.0: Six Months to Two Years Post-HSCT Data

Center: CRID:

487 anti CD5
   yes □ no □

488 anti CD6
   yes □ no □

489 anti CD7
   yes □ no □

490 anti CD8
   yes □ no □

491 anti CD34
   yes □ no □

492 anti TCR alpha / beta (T10-B9)
   yes □ no □

493 OKT-3
   yes □ no □

494 other CD3
   yes □ no □

495 Specify other CD3: ____________________________

496 anti CD52
   yes □ no □

Specify antibodies:

497 campath-NOS
   yes □ no □

498 campath-1G
   yes □ no □

499 campath-1H
   yes □ no □

500 other antibody
   yes □ no □

501 Specify other antibody: ____________________________

First Name: __________________________ Last Name: __________________________
Phone number: __________________________ Fax number: __________________________
E-mail address: __________________________