Vital Status

1. Is the data reported on this form based on contact with the physician? □
   1 □ yes
   2 □ no

2. Date of actual contact with recipient to determine medical status for this follow-up report:
   □
   Month □ Day □ Year

3. 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? □
   1 □ yes
   2 □ no

   Answers to subsequent questions should reflect clinical status immediately prior to start of the preparative regimen for subsequent HSCT. Complete Subsequent HSCT questions 213–220.

4. Specify the recipient’s survival status at the date of actual contact:
   1 □ alive
   2 □ dead

   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 2).

   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.

5. Has the recipient received a donor cellular infusion (DCI) since the date of contact from the last report? □
   1 □ yes
   2 □ no

   Complete DCI Information questions 221–319.

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.
### Functional Status

6. Specify the functional status of the recipient on the date of last actual contact (table below). If the recipient has died, skip this question and continue with question 7.

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

7. Specify other occupation:

Continue with question 11

8. Specify other occupation:

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

<table>
<thead>
<tr>
<th>Status Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>full time</td>
<td>1</td>
</tr>
<tr>
<td>part time</td>
<td>2</td>
</tr>
<tr>
<td>unemployed</td>
<td>3</td>
</tr>
<tr>
<td>medical disability</td>
<td>4</td>
</tr>
<tr>
<td>retired</td>
<td>5</td>
</tr>
<tr>
<td>unknown</td>
<td>6</td>
</tr>
</tbody>
</table>

10. Specify retirement status:

<table>
<thead>
<tr>
<th>Status Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>with a source of income</td>
<td>1</td>
</tr>
<tr>
<td>no source of income</td>
<td>2</td>
</tr>
</tbody>
</table>
The next two sections relate to graft-vs.-host disease from allogeneic HSCTs only. If this was an autologous HSCT, continue with the New Malignancies section at question 131.

Acute Graft vs. Host Disease (GVHD)

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

1. Yes
2. No
3. Unknown

Continue with section 59

12. Date of acute GVHD diagnosis: [Month Day Year]

Date was previously reported

13. Was the diagnosis based on evidence from a biopsy (histology)?

1. Yes
2. No

Specify result(s):

- positive
- negative
- inconclusive tested
- not tested

14. 1. gastrointestinal (GI)
2. liver
3. lung
4. skin
5. other site

15. 1. gastrointestinal (GI)
2. liver
3. lung
4. skin
5. other site

16. 1. gastrointestinal (GI)
2. liver
3. lung
4. skin
5. other site

17. 1. gastrointestinal (GI)
2. liver
3. lung
4. skin
5. other site

18. 1. gastrointestinal (GI)
2. liver
3. lung
4. skin
5. other site

19. Specify other site:

20. Is a copy of the pathology report attached?

1. Yes
2. No

List the maximum severity of organ involvement:

21. Was the diagnosis based on clinical evidence?

1. Yes
2. No

22. Maximum overall grade of acute GVHD:

1. I
2. II
3. III
4. IV

23. Is acute GVHD still present at the date of contact for this report (question 2)?

1. Yes
2. No
3. progressed to chronic GVHD
4. Unknown

24. 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

25. 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 mL/day or ≤ 1000 mL/day or 280-555 mL/m²/day
5. stage 2 – diarrhea > 1000 mL/day or ≤ 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
26. Upper intestinal tract:
   1. stage 0 – no persistent nausea or vomiting
   2. stage 1 – persistent nausea or vomiting

27. 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)

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

29. Specify site:
   lung

30. Specify:
   other

31. Specify:

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

33. ALS, ALG, ATS, ATG
   1. yes
   2. no

34. Specify source:
   1. horse
   2. rabbit
   3. other

35. Specify:

36. Corticosteroids (systemic)
   1. yes
   2. no

37. Corticosteroids (topical)
   1. yes
   2. no

38. Cyclosporine (CSA) (Sandimmune, Neoral)
   1. yes
   2. no

39. ECP (extra-corporeal photopheresis)
   1. yes
   2. no

40. FK 506 (Tacrolimus, Prograf)
   1. yes
   2. no

41. In vivo monoclonal antibody
   1. yes
   2. no

42. Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
   1. yes
   2. no

43. Specify:

44. Campath
   1. yes
   2. no

45. Etanercept (Enbrel)
   1. yes
   2. no

46. Infliximab (Remicade)
   1. yes
   2. no

47. Other in vivo monoclonal antibody
   1. yes
   2. no

48. Specify:

49. In vivo immunotoxin
   1. yes
   2. no

50. Specify:

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
Chronic Graft vs. Host Disease (GVHD)

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

1 □ yes  2 □ no 甲氨蝶呤 (MTX) (Amethopterin)

52. 1 □ yes  2 □ no 甲氨蝶呤 (MTX) (Amethopterin)

53. 1 □ yes  2 □ no 他克莫司 (Rapamycin, Rapamune)

54. 1 □ yes  2 □ no 依维莫司 (Rapamune)

55. 1 □ yes  2 □ no 他克莫司 (Rapamycin, Rapamune)

58. Specify:

60. Date of chronic GVHD diagnosis:

61. Onset of chronic GVHD was:

1 □ progressive (acute GVHD progressed directly to chronic GVHD)

2 □ interrupted (acute GVHD resolved, then chronic GVHD developed)

3 □ de novo (acute GVHD never developed)

4 □ chronic GVHD flare (symptoms reactivated within 30 days of drug tapering or discontinuation)

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

(See page 2 for scale descriptions.)

63. Platelet count at diagnosis of chronic GVHD:

1 □ x 10^9/L (x 10^3/mm³)

2 □ x 10^9/L

64. Diagnosis was based on:

1 □ histologic evidence / biopsy proven

2 □ clinical evidence

3 □ both

4 □ unknown

65. Maximum grade of chronic GVHD:

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

2 □ 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

66. Overall severity of chronic GVHD:

1 □ 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 □ 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 □ 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:

<table>
<thead>
<tr>
<th>Organ / System</th>
<th>If yes, was involvement proven by biopsy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>67. Sclerosis of skin</td>
<td>68. yes 2 no</td>
</tr>
<tr>
<td>69. Other skin or hair involvement (rash, ulcers, pruritus or itching, dyspigmentation, alopecia, pruritus or pruritus changes, etc.)</td>
<td>70. yes 2 no</td>
</tr>
<tr>
<td>71. Eyes (xerophthalmia (dry eyes), abnormal Schirmer’s test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)</td>
<td>72. yes 2 no</td>
</tr>
<tr>
<td>73. Mouth (lichenoid changes, mucositis / ulcers, erythema, etc.)</td>
<td>74. yes 2 no</td>
</tr>
<tr>
<td>75. Bronchiolitis obliterans</td>
<td>76. yes 2 no</td>
</tr>
<tr>
<td>77. Other lung involvement</td>
<td>78. yes 2 no</td>
</tr>
<tr>
<td>79. Gastrointestinal tract (esophageal involvement, chronic nausea / vomiting, chronic diarrhea, malabsorption, abdominal pain / cramps, etc.)</td>
<td>80. yes 2 no</td>
</tr>
<tr>
<td>81. Liver</td>
<td>82. yes 2 no</td>
</tr>
<tr>
<td>83. Genitourinary tract (vaginitis / stricture, etc.)</td>
<td>84. yes 2 no</td>
</tr>
<tr>
<td>85. Musculoskeletal (arthritis, contractures, myositis, myasthenia, etc.)</td>
<td>86. yes 2 no</td>
</tr>
<tr>
<td>87. Thrombocytopenia (&lt; 100 x 10^9/L)</td>
<td>88. yes 2 no</td>
</tr>
<tr>
<td>89. Eosinophilia</td>
<td>90. yes 2 no</td>
</tr>
<tr>
<td>91. Autoantibodies</td>
<td>92. yes 2 no</td>
</tr>
<tr>
<td>93. Other hematologic involvement</td>
<td>94. yes 2 no</td>
</tr>
<tr>
<td>95. Weight loss</td>
<td>96. yes 2 no</td>
</tr>
<tr>
<td>97. Other organ involvement from chronic GVHD</td>
<td>98. yes 2 no</td>
</tr>
</tbody>
</table>

Was specific therapy used to treat chronic GVHD?

1. yes 2 no

Specify:

- 98. ALS, ALG, ATS, ATG
- 99. Specify source:
  - 1. horse
  - 2. rabbit
  - 3. other
- 100. Specify:

- 101. Azathioprine
- 102. Corticosteroids (systemic)
- 103. Corticosteroids (topical)
- 104. Cyclosporine (CSA) (Sandimmune, Neoral)
- 105. ECP (extracorporeal photopheresis)
- 106. Eretinate
- 107. FK 506 (Tacrolimus, Prograf)
- 108. Hydroxychloroquine (Plaquenil)
128. Are symptoms of chronic GVHD still present on the date of actual contact (or present at the time of death)?
1 □ yes
2 □ no

129. Is recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD? 
1 □ yes
2 □ no

130. Date final treatment administered: Month Day Year
□ date unknown □ date was previously reported

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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
131. 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 □ yes 2 □ no

Specify which new disease(s) occurred:

132. □ yes □ no acute myeloid leukemia (AML / ANLL)

133. Date of diagnosis: Month Day Year

134. □ yes □ no other leukemia, including ALL

135. Date of diagnosis: Month Day Year

136. Specify: ______________________

137. □ yes □ no breast cancer

138. Date of diagnosis: Month Day Year

139. □ yes □ no central nervous system (CNS) malignancy (glioblastoma, astrocytoma)

140. Date of diagnosis: Month Day Year

141. □ yes □ no clonal cytogenetic abnormality without leukemia or MDS

142. Date of diagnosis: Month Day Year

143. □ yes □ no gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)

144. Date of diagnosis: Month Day Year

145. □ yes □ no genitourinary malignancy (kidney, bladder, ovary, testicle genitalia, uterus, cervix)

146. Date of diagnosis: Month Day Year

147. □ yes □ no Hodgkin disease

148. Date of diagnosis: Month Day Year

149. □ yes □ no lung cancer

150. Date of diagnosis: Month Day Year

151. □ yes □ no lymphoma or lymphoproliferative disease

152. Date of diagnosis: Month Day Year

153. Is the tumor EBV positive?

1 □ yes 2 □ no

154. □ yes □ no melanoma

155. Date of diagnosis: Month Day Year

156. □ yes □ no other skin malignancy (basal cell, squamous)

157. Date of diagnosis: Month Day Year

158. Specify: ______________________

159. □ yes □ no myelodysplasia (MDS) / myeloproliferative (MPS) disorder

158. Specify: ______________________

160. Date of diagnosis: Month Day Year

161. □ yes □ no oropharyngeal cancer (tongue, buccal mucosa)

162. Date of diagnosis: Month Day Year

163. □ yes □ no sarcoma

164. Date of diagnosis: Month Day Year

165. □ yes □ no thyroid cancer

166. Date of diagnosis: Month Day Year

167. □ yes □ no other new malignancy

168. Date of diagnosis: Month Day Year

169. Specify: ______________________

170. 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 170 on the report.
Other Organ Impairment / Disorder

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

<table>
<thead>
<tr>
<th>Impairment / Disorder</th>
<th>Date of diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>avascular necrosis</td>
<td></td>
</tr>
<tr>
<td>bronchiolitis obliterans (BO)</td>
<td></td>
</tr>
<tr>
<td>cataracts</td>
<td></td>
</tr>
<tr>
<td>congestive heart failure (EF &lt; 40%)</td>
<td></td>
</tr>
<tr>
<td>cryptogenic organizing pneumonia (COP)</td>
<td></td>
</tr>
<tr>
<td>diabetes / hyperglycemia</td>
<td></td>
</tr>
<tr>
<td>gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)</td>
<td></td>
</tr>
<tr>
<td>growth hormone deficiency / growth disturbance</td>
<td></td>
</tr>
<tr>
<td>hemorrhagic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transfusions, urology consult)</td>
<td></td>
</tr>
<tr>
<td>hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>interstitial pneumonitis (IPn) / ARDS</td>
<td></td>
</tr>
<tr>
<td>myocardial infarction</td>
<td></td>
</tr>
<tr>
<td>non-infectious liver toxicity</td>
<td></td>
</tr>
<tr>
<td>pancreatitis</td>
<td></td>
</tr>
<tr>
<td>post-transplant microangiopathy-thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS), or similar syndrome</td>
<td></td>
</tr>
<tr>
<td>pulmonary hemorrhage</td>
<td></td>
</tr>
<tr>
<td>renal failure severe enough to warrant dialysis</td>
<td></td>
</tr>
<tr>
<td>stroke / seizure</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
</tbody>
</table>

202. Did the recipient receive plasmapheresis?

1. yes
2. no

204. pulmonary hemorrhage

206. renal failure severe enough to warrant dialysis

208. stroke / seizure

210. other

212. Specify impairment / disorder:
Subsequent HSCT □

Complete this section if the recipient received a subsequent HSCT (question 3, answered “yes”). If the recipient received only DCIs with no subsequent HSCTs, continue with question 221. If no subsequent HSCTs or DCIs were performed, continue with the signature lines at question 320.

213. Date of subsequent HSCT:  
   Month   Day   Year

214. Was the subsequent HSCT performed at a different institution?
   1 □ yes  
   2 □ no

215. Specify the institution that performed the subsequent HSCT:
   Name:  
   City:  
   State / Country:  

216. 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  

217. Specify:  

218. Source of HSCs:
   1 □ allogeneic, related  
   2 □ allogeneic, unrelated  
   3 □ autologous  

   Complete a new Form 2000 — Recipient Baseline Data.

219. Was the same donor used?
   1 □ yes  
   2 □ no

220. Specify:
   1 □ fresh, original NMDP donor bone marrow  
   2 □ fresh, original non-NMDP donor bone marrow  
   3 □ fresh, second NMDP donor bone marrow  
   4 □ fresh, second 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, second NMDP donor mobilized peripheral blood stem cells  
   8 □ fresh, second 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
Donor Cellular Infusion (DCI) Information

This section captures information on DCIs (question 5, 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 recieve any DCIs, continue with the signature lines at question 320.

221. Date the first DCI was given: __________ ____________

222. Specify the total number of cell infusions given within 10 weeks of the first DCI: __________

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

224. Specify the institution that performed the DCI:
   Name: __________________________
   City: __________________________
   State / Country: ______________________

225. Indication for DCI:
   1 □ planned as part of initial HSCT protocol
   2 □ treatment for relapsed, persistent or progressive disease
   3 □ treatment for B cell lymphoproliferative 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

226. 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 221).

   positive | negative | not done / unknown
   226. 1 □ | 2 □ | 3 □ molecular | 227. Date: __________ __________ __________
   228. 1 □ | 2 □ | 3 □ cytogenetic | 229. Date: __________ __________ __________
   230. 1 □ | 2 □ | 3 □ clinical evidence / hematologic | 231. Date: __________ __________ __________

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

233. Date of administration of final chemotherapy dose: __________ __________ __________

234. Specify viral organism code: (see manual for code list) __________

235. Date documented: __________ __________ __________

236. Specify indication: __________________________

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

CIBMTR Center Number: ____________________________

Today's Date: 2020

Infusion Date: 2020

CIBMTR Center Number: ____________________________

CIBMTR Recipient ID: ____________________________

238. Date disease status was established prior to the first DCI:
   Month Day Year

239. Specify the functional status of the recipient immediately prior to the first DCI:
   (See page 2 for Karnofsky / Lansky Scale descriptions.)

Specify DCI source:
240. 1 yes 2 no collected at the time of PBSC mobilization and collection
241. 1 yes 2 no negative fraction of CD34 selected PBSC
242. 1 yes 2 no negative fraction of CD34 selected bone marrow
243. 1 yes 2 no apheresis at a different time than collection of PBSC used for allogeneic HSCT

245. 1 yes 2 no isolated from a unit(s) of whole blood

246. Specify number of units:

244. Date of apheresis:
   Month Day Year

247. Were the donor cells collected by leukapheresis?
1 yes 2 no

248. Date of first leukapheresis:
   Month Day Year

249. Date of last leukapheresis:
   Month Day Year

250. Number of leukaphereses:

251. Did the donor receive treatment to enhance cell collection prior to donation?
1 yes 2 no

Specify treatment(s) given:
252. Growth factors
   1 yes 2 no

253. 1 yes 2 no G-CSF
254. 1 yes 2 no GM-CSF
255. 1 yes 2 no Other agent

257. Other treatment
   1 yes 2 no

258. Specify:

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.

Total cells: Specify exponent: E

259. CD3+ cells: x 10 □ not tested

260. CD4+ cells: x 10 □ not tested

261. CD8+ cells: x 10 □ not tested

262. CD34+ cells: x 10 □ not tested

263. NK cells: x 10 □ not tested

264. Nucleated cells: x 10 □ not tested

265. Mesenchymal cells: x 10 □ not tested

CIBMTR Form 2300 v1.0 (12–14) July 2007
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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
266. Were dendritic cells infused?
   1 [ ] yes
   2 [ ] no

267. Were fibroblasts infused?
   1 [ ] yes
   2 [ ] no

268. Were any other cell types infused (not including cell types reported in questions 259–265)?
   1 [ ] yes
   2 [ ] no

270. Were the cells cryopreserved prior to infusion?
   1 [ ] yes
   2 [ ] no

272. Were the cells manipulated prior to infusion?
   1 [ ] yes
   2 [ ] no

271. Specify portion cryopreserved:
   1 [ ] all cells
   2 [ ] portion of cells

273. Specify portion manipulated:
   1 [ ] all cells
   2 [ ] portion of cells

Specify all methods used to manipulate the cells:

274. ABO incompatibility
   1 [ ] yes
   2 [ ] no

Specify method:

275. [ ] buffy coat preparation
276. [ ] cell separator (i.e., COBE Spectra)
277. [ ] density gradient separation (i.e., Ficoll)
278. [ ] plasma removal
279. [ ] sedimentation (i.e., hetastarch)
280. [ ] other

281. Specify:

282. [ ] dextran-albumin wash
283. [ ] ex-vivo expansion
284. [ ] genetic manipulation (gene transfer / transduction)
285. [ ] volume reduction

286. CD34+ selection
   1 [ ] yes
   2 [ ] no

287. Specify manufacturer:
   1 [ ] CliniMACS / CliniMax
   2 [ ] Isolex
   3 [ ] other

288. Specify:

289. T-cell depletion
   1 [ ] yes
   2 [ ] no

Specify method:

290. [ ] antibody affinity column
291. [ ] antibody coated plates
292. [ ] antibody + complement
293. [ ] antibody + toxin
294. [ ] immunomagnetic beads
295. [ ] elutriation
296. [ ] other
297. [ ] CD34 affinity column plus sheep red blood cell rosetting

298. [ ] other

299. Specify:

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300. other manipulation

1 ☐ yes
2 ☐ no

301. Specify: _____________________________

302. Were antibodies used during graft manipulation?

1 ☐ yes
2 ☐ no

Specify antibodies:
303. 1 ☐ yes 2 ☐ no anti CD2
304. 1 ☐ yes 2 ☐ no anti CD4
305. 1 ☐ yes 2 ☐ no anti CD5
306. 1 ☐ yes 2 ☐ no anti CD6
307. 1 ☐ yes 2 ☐ no anti CD7
308. 1 ☐ yes 2 ☐ no anti CD8
309. 1 ☐ yes 2 ☐ no anti CD34
310. 1 ☐ yes 2 ☐ no anti TCR alpha / beta (T10-B9)
311. 1 ☐ yes 2 ☐ no OKT-3
312. 1 ☐ yes 2 ☐ no other CD3

313. Specify: _____________________________

314. 1 ☐ yes 2 ☐ no anti CD52

Specify antibodies:
315. 1 ☐ yes 2 ☐ no campath-NOS
316. 1 ☐ yes 2 ☐ no campath-1G
317. 1 ☐ yes 2 ☐ no campath-1H

318. 1 ☐ yes 2 ☐ no other antibody

319. Specify: _____________________________

320. Signed: _____________________________

Person completing form

Please print name: _____________________________

Phone: (___________) _____________________________

Fax: (___________) _____________________________

E-mail address: _____________________________

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