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 216–223.

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 224–322.
Functional Status

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

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
1 100 Normal; no complaints; no evidence of disease
2 90 Able to carry on normal activity
3 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
4 70 Cares for self; unable to carry on normal activity or to do active work
5 60 Requires occasional assistance but is able to care for most needs
6 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
7 40 Disabled; requires special care and assistance
8 30 Severely disabled; hospitalization indicated, although death not imminent
9 20 Very sick; hospitalization necessary
10 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
1 100 Fully active
2 90 Minor restriction in physically strenuous play
3 80 Restricted in strenuous play, tires more easily, otherwise active
Mild to moderate restriction
4 70 Both greater restrictions of, and less time spent in, active play
5 60 Ambulatory up to 50% of time, limited active play with assistance / supervision
6 50 Considerable assistance required for any active play; fully able to engage in quiet play
Moderate to severe restriction
7 40 Able to initiate quiet activities
8 30 Needs considerable assistance for quiet activity
9 20 Limited to very passive activity initiated by others (e.g., TV)
10 10 Completely disabled, not even passive play

7. 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 11

8. Specify other occupation:

9. 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

10. Specify retirement status:
1 ☐ with a source of income
2 ☐ no source of income
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 59

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.

12. Date of acute GVHD diagnosis:
Month
Day
Year

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

Specify result(s):

inconclusive tested
positive negative

14. Gastrointestinal (GI)
15. Liver
16. Lung
17. Skin
18. Other site

19. Specify other site:

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

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 1)?
1. yes
2. no
3. progressed to chronic GVHD
4. unknown

List the maximum severity of organ involvement:

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 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
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:
   1. Lung
   2. Other site

30. Specify other site:

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

33. Specify therapy administered to treat acute GVHD:
   1. ALS, ALG, ATS, ATG

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

35. Specify source:

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 anti CD25:

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 antibody:

49. In vivo immunotoxin
   1. yes
   2. no

50. Specify immunotoxin:
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

3. no symptoms, but recipient is receiving treatment

4. unknown

Continue with 97

60. Date of chronic GVHD diagnosis:

Month Day Year

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:

63. Platelet count at diagnosis of chronic GVHD:


1. $x 10^{9}/L$ (x $10^{3}/mm^3$)
2. $x 10^{6}/L$

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

55. 1 yes 2 no

56. Specify trial agent:

57. 1 yes 2 no

58. Specify other agent:

51. 1 yes 2 no Methotrexate (MTX) (Amethopterin)

52. 1 yes 2 no Mycophenolate mofetil (MMF) (CellCept)

53. 1 yes 2 no Sirolimus (Rapamycin, Rapamune)

54. 1 yes 2 no Ursodiol

55. 1 yes 2 no Blinded randomized trial

56. Specify trial agent:

57. 1 yes 2 no Other agent

58. Specify other agent:

CIBMTR Form 2300 revision 2 (page 5 of 14) June 2009
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Internal use: Document number F00484 revision 2  Replaces: F00484 version 1.0 July 2007
## 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>yes 2 no</td>
</tr>
<tr>
<td>68. Other skin or hair involvement (rash, ulcers,</td>
<td>2 no</td>
</tr>
<tr>
<td>69. pruritus itching, dyspigmentation, alopecia,</td>
<td></td>
</tr>
<tr>
<td>70. pruritus changes, etc.)</td>
<td></td>
</tr>
<tr>
<td>71. Eyes (xerophthalmia (dry eyes), abnormal Schirmer's test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>72. Mouth (lichenoid changes, mucositis / ulcers,</td>
<td></td>
</tr>
<tr>
<td>73. erythema, etc.)</td>
<td></td>
</tr>
<tr>
<td>74. Bronchiolitis obliterans</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>75. Gastrointestinal tract (esophageal involvement,</td>
<td></td>
</tr>
<tr>
<td>76. chronic nausea / vomiting, chronic diarrhea,</td>
<td></td>
</tr>
<tr>
<td>77. malabsorption, abdominal pain / cramps, etc.)</td>
<td></td>
</tr>
<tr>
<td>78. Liver</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>79. Genitourinary tract (vaginitis / stricture, etc.)</td>
<td></td>
</tr>
<tr>
<td>80. Musculoskeletal (arthritis, contractures, myositis, myasthenia, etc.)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>81. Thrombocytopenia (&lt; 100 x 10^9/L)</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>82. Eosinophilia</td>
<td></td>
</tr>
<tr>
<td>83. Autoantibodies</td>
<td></td>
</tr>
<tr>
<td>84. Other hematologic involvement</td>
<td></td>
</tr>
<tr>
<td>85. Serositis</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>86. Weight loss</td>
<td></td>
</tr>
<tr>
<td>87. Other organ involvement from chronic GVHD</td>
<td>yes 2 no</td>
</tr>
<tr>
<td>88. Thrombocytopenia (&lt; 100 x 10^9/L)</td>
<td></td>
</tr>
<tr>
<td>89. Eosinophilia</td>
<td></td>
</tr>
<tr>
<td>90. Autoantibodies</td>
<td></td>
</tr>
<tr>
<td>91. Serositis</td>
<td></td>
</tr>
<tr>
<td>92. Weight loss</td>
<td></td>
</tr>
<tr>
<td>93. Other organ involvement from chronic GVHD</td>
<td></td>
</tr>
</tbody>
</table>

96. Specify site:

97. Was specific therapy used to treat chronic GVHD?

1 yes 2 no

Specify therapy:

98. ALS, ALG, ATS, ATG

1 yes 2 no

Specify source:

1 horse

2 rabbit

3 other

100. Specify source:

101. Azathioprine

102. Corticosteroids (systemic)

103. Corticosteroids (topical)

104. Cyclosporine (CSA) (Sandimmune, Neoral)

105. ECP (extracorporeal photopheresis)

106. Etretinate

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 the recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD?
  1) yes
  2) no
  3) unknown

New Malignancy
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

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

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

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

Attach a copy of the report with all identifiers removed, except for birth date and ID numbers. Reference question 134 on the report.
Specify which new disease(s) occurred:

<table>
<thead>
<tr>
<th>No.</th>
<th>1</th>
<th>2</th>
<th>Disease Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>135</td>
<td>☐</td>
<td>☑</td>
<td>Acute myeloid leukemia (AML / ANLL)</td>
</tr>
<tr>
<td>136</td>
<td>☐</td>
<td>☑</td>
<td>Other leukemia, including ALL</td>
</tr>
<tr>
<td>140</td>
<td>☐</td>
<td>☑</td>
<td>Breast cancer</td>
</tr>
<tr>
<td>141</td>
<td>☐</td>
<td>☑</td>
<td>Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)</td>
</tr>
<tr>
<td>144</td>
<td>☐</td>
<td>☑</td>
<td>Clonal cytogenetic abnormality without leukemia or MDS</td>
</tr>
<tr>
<td>145</td>
<td>☐</td>
<td>☑</td>
<td>Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)</td>
</tr>
<tr>
<td>148</td>
<td>☐</td>
<td>☑</td>
<td>Genitourinary malignancy (kidney, bladder, ovary, testicle genitalia, uterus, cervix)</td>
</tr>
<tr>
<td>150</td>
<td>☐</td>
<td>☑</td>
<td>Hodgkin disease</td>
</tr>
<tr>
<td>152</td>
<td>☐</td>
<td>☑</td>
<td>Lung cancer</td>
</tr>
<tr>
<td>154</td>
<td>☐</td>
<td>☑</td>
<td>Lymphoma or lymphoproliferative disease</td>
</tr>
<tr>
<td>157</td>
<td>☐</td>
<td>☑</td>
<td>Melanoma</td>
</tr>
<tr>
<td>159</td>
<td>☐</td>
<td>☑</td>
<td>Other skin malignancy (basal cell, squamous)</td>
</tr>
<tr>
<td>162</td>
<td>☐</td>
<td>☑</td>
<td>Myelodysplasia (MDS) / myeloproliferative (MPS) disorder</td>
</tr>
<tr>
<td>164</td>
<td>☐</td>
<td>☑</td>
<td>Oropharyngeal cancer (tongue, buccal mucosa)</td>
</tr>
<tr>
<td>166</td>
<td>☐</td>
<td>☑</td>
<td>Sarcoma</td>
</tr>
<tr>
<td>168</td>
<td>☐</td>
<td>☑</td>
<td>Thyroid cancer</td>
</tr>
<tr>
<td>170</td>
<td>☐</td>
<td>☑</td>
<td>Other new malignancy</td>
</tr>
</tbody>
</table>

Date of diagnosis:

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

156. Is the tumor EBV positive?

1. ☐ yes
2. ☑ no

Specify other skin malignancy:

151. ☐ yes
2. ☑ no

Specify other new malignancy:

155. ☐ yes
2. ☑ no

173. 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 173 on the report.
### Other Organ Impairment / Disorder

174. 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>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avascular necrosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchiolitis obliterans (BO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure (EF &lt; 40%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryptogenic organizing pneumonia (COP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes / hyperglycemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth hormone deficiency / growth disturbance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhagic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transfusions, urology consult)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interstitial pneumonitis (IPn) / ARDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-infectious liver toxicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-transplant microangiopathy-thrombocytopenic purpura (TPP), hemolytic uremic syndrome (HUS), or similar syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary hemorrhage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal failure severe enough to warrant dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke / seizure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

175. 1 □ yes 2 □ no Avascular necrosis

176. 1 □ yes 2 □ no Date of diagnosis

---

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

Complete this section if the recipient received a subsequent HSCT (question 3, answered “yes”). If no subsequent HSCTs were performed, continue with the DCI section at question 323.

216. Date of subsequent HSCT:

Month Day Year

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

1 yes
2 no

218. Specify the institution that performed the subsequent HSCT:

Name: ____________________________
City: ____________________________
State / Country: ____________________

219. 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

Complete the section on New Malignancy (questions 131–173).

220. Specify other indication: ____________________________

221. Source of HSCs:

If more than one product is infused, copy and complete questions 221–223 for each product.

1 allogeneic, related

Complete a new Form 2000 — Recipient Baseline Data.

222. Was the same donor used?

1 yes
2 no

2 allogeneic, unrelated

Complete a new Form 2000 — Recipient Baseline Data.

223. 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 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 receive any DCIs, continue with the signature lines at question 323.

224. Date the first DCI was given: Month Day Year

225. Specify the total number of cell infusions given within 10 weeks of the first DCI: _____________

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

227. Specify the institution that performed the DCI:
   Name: ____________________________
   City: ______________________________
   State / Country: ____________________

228. 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

   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 224).

   229. 1  molecular
   2  positive
   3  negative
   4  unknown
   230. Date: Month Day Year

   231. 1  cytogenetic
   2  positive
   3  negative
   232. Date: Month Day Year

   233. 1  clinical evidence / hematologic
   2  positive
   3  negative
   234. Date: Month Day Year

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

   236. Date of administration of final chemotherapy dose: Month Day Year

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

238. Date documented: Month Day Year

239. Specify other indication: ____________________________

240. 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

   Continue with question 242

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
## CIBMTR Form 2300

### CIBMTR Center Number:

<table>
<thead>
<tr>
<th>Sequence Number</th>
<th>CIBMTR Recipient ID</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Today's Date:</th>
<th>Infusion Date:</th>
<th>CIBMTR Center Number:</th>
<th>Visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month Day Year</td>
<td>Month Day Year</td>
<td></td>
<td>years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIBMTR Recipient ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### 241. Date disease status was established prior to the first DCI:

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

### 242. Specify the functional status of the recipient immediately prior to the first DCI:

(see page 2 for Karnofsky / Lansky Scale descriptions)

### Specify DCI source:

- 243. 1 ☐ yes 2 ☐ no Collected at the time of PBSC mobilization and collection
- 244. 1 ☐ yes 2 ☐ no Negative fraction of CD34 selected PBSC
- 245. 1 ☐ yes 2 ☐ no Negative fraction of CD34 selected bone marrow
- 246. 1 ☐ yes 2 ☐ no Apheresis at a different time than collection of PBSC used for allogeneic HSCT

247. Date of apheresis:

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

### 248. 1 ☐ yes 2 ☐ no Isolated from a unit(s) of whole blood

249. Specify number of units:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
</table>

### 250. Were the donor cells collected by leukapheresis?

- 1 ☐ yes
- 2 ☐ no

251. Date of first leukapheresis:

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

252. Date of last leukapheresis:

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

253. Number of leukaphereses:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
</table>

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

- 1 ☐ yes
- 2 ☐ no

255. Specify treatment(s) given:

#### 256. Growth factors

- 1 ☐ yes
- 2 ☐ no

- Specify agent:
  - 256. 1 ☐ yes 2 ☐ no G-CSF
  - 257. 1 ☐ yes 2 ☐ no GM-CSF
  - 258. 1 ☐ yes 2 ☐ no Other agent

259. Specify other agent:

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
</table>

#### 260. Other treatment

- 1 ☐ yes
- 2 ☐ no

261. Specify other treatment:

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>Specify exponent:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ not tested</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CD3+ cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CD4+ cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CD8+ cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CD34+ cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NK cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nucleated cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mesenchymal cells:</th>
<th>x 10</th>
</tr>
</thead>
</table>

### Fax instructions:

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>269. Were dendritic cells infused?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>270. Were fibroblasts infused?</td>
<td></td>
<td></td>
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<tr>
<td>271. Were any other cell types infused (not including cell types</td>
<td></td>
<td></td>
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<tr>
<td>reported in questions 262–268)?</td>
<td></td>
<td></td>
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<tr>
<td>272. Specify other cell type(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>273. Were the cells cryopreserved prior to infusion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>274. Specify portion cryopreserved:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>275. Were the cells manipulated prior to infusion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>276. Specify portion manipulated:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>277. ABO incompatibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>278. Specify method:</td>
<td></td>
<td></td>
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<tr>
<td>279. Dextran-albumin wash</td>
<td></td>
<td></td>
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<tr>
<td>280. Ex-vivo expansion</td>
<td></td>
<td></td>
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<tr>
<td>281. Genetic manipulation (gene transfer / transduction)</td>
<td></td>
<td></td>
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<tr>
<td>282. Volume reduction</td>
<td></td>
<td></td>
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<tr>
<td>283. CD34+ selection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>284. Specify other method</td>
<td></td>
<td></td>
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<tr>
<td>285. Buffy coat preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>286. Cell separator (i.e., COBE Spectra)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>287. Density gradient separation (i.e., Ficoll)</td>
<td></td>
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<tr>
<td>288. Plasma removal</td>
<td></td>
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<tr>
<td>289. Sedimentation (i.e., hetastarch)</td>
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<tr>
<td>290. Specify manufacturer</td>
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<td></td>
</tr>
<tr>
<td>291. Specify other manufacturer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>292. T-cell depletion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>293. Antibody affinity column</td>
<td></td>
<td></td>
</tr>
<tr>
<td>294. Antibody coated plates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>295. Antibody coated plates and soybean lectin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>296. Antibody + complement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>297. Antibody + toxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>298. Immunomagnetic beads</td>
<td></td>
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<tr>
<td>299. Elutriation</td>
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<td></td>
</tr>
<tr>
<td>300. CD34 affinity column plus sheep red blood cell rosetting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>301. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Report antibodies used for T-cell depletion at question 305.
303. Other cell manipulation
1 □ yes 2 □ no

304. Specify other cell manipulation: ______________________

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

Specify antibodies:
306. 1 □ yes 2 □ no Anti CD2
307. 1 □ yes 2 □ no Anti CD4
308. 1 □ yes 2 □ no Anti CD5
309. 1 □ yes 2 □ no Anti CD6
310. 1 □ yes 2 □ no Anti CD7
311. 1 □ yes 2 □ no Anti CD8
312. 1 □ yes 2 □ no Anti CD34
313. 1 □ yes 2 □ no Anti TCR alpha / beta (T10-B9)
314. 1 □ yes 2 □ no OKT-3
315. 1 □ yes 2 □ no Other CD3

316. Specify other CD3: ______________________

317. 1 □ yes 2 □ no Anti CD52

Specify antibodies:
yes no
318. 1 □ 2 □ Campath-NOS
319. 1 □ 2 □ Campath-1G
320. 1 □ 2 □ Campath-1H

321. 1 □ yes 2 □ no Other antibody

322. Specify other antibody: ______________________

323. Signed: ____________________________________________

Person completing form

Please print name: _________________________________________

Phone: (___________) ______________________________________

Fax: (___________) ________________________________________

E-mail address: ___________________________________________