**Key Fields**

- **Sequence Number:**
- **Date Received:** __ __ __ __ - __ __ - __ __
- **CIBMTR Center Number:**
- **CIBMTR Recipient ID:**
- **Today's Date:** __ __ __ __ - __ __ - __ __
- **Date of HSCT for which this form is being completed:** __ __ __ __ - __ __ - __ __
- **HSCT Type (check all that apply):**
  - Autologous
  - Allogeneic, unrelated
  - Allogeneic, related
  - Syngeneic (identical twin)
- **Product type (check all that apply):**
  - Marrow
  - PBSC
  - Cord blood
  - multiple cord blood units infused
  - Other product
    - Specify: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ 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**Vital Status Questions: 1 - 5**

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

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

3. 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
   - no

4. Specify the recipient's survival status at the date of actual contact:
   - Alive
   - Dead

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

**Functional Status Questions: 6 - 10**

6. Which scale was used, Karnofsky or Lansky?
   - Karnofsky
   - Lansky
Select the phrase in the Karnofsky/Lanksy Play Performance Scale which best describes the activity status of the recipient.

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.

Specify the functional status of the recipient on the date of last actual contact.

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:

- 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

8 Specify other occupation: __________________________________________

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

- full time
- part time
- unemployed
- medical disability
- retired
- recipient < 16 years old
- Unknown
### Form 2300 R3.0: Yearly Follow-up for Greater Than Two Years Post-HSCT Data

**Center:**

**CRID:**

---

**10** Specify retirement status:
- with a source of income
- no source of income

---

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

---

**12** Date of acute GVHD diagnosis: __ __ __ __ - __ __ __ __

**13** Was the diagnosis based on evidence from a biopsy (histology)?
- yes
- no

**Specify result(s):**
- gastrointestinal (GI)
  - Positive
  - Negative
  - Inconclusive
  - Not tested

**14** Liver
- Positive
- Negative
- Inconclusive
- Not tested

**15** Lung
- Positive
- Negative
- Inconclusive
- Not tested

**16** Skin
- Positive
- Negative
- Inconclusive
- Not tested

**17** Other site
- Positive
- Negative
- Inconclusive
- Not tested

**18** Specify: ___________________________

**19** Is a copy of the pathology report attached?
- yes
- no

**20** Was the diagnosis based on clinical evidence?
- yes
- no

**21** Maximum overall grade of acute GVHD:
- I
- II
- III
- IV

**22** Is acute GVHD still present at the date of contact for this report (question 2)?
- Yes
- No
- progressed to chronic GVHD
- Unknown
List the maximum severity of organ involvement:

24 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

25 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

26 Upper intestinal tract:

- stage 0 - no persistant nausea or vomiting
- stage 1 - persistant nausea or vomiting

27 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)

28 Other clinical organ involvement?

- yes
- no

Specify site:

29 Lung

- yes
- no
Form 2300 R3.0: Yearly Follow-up for Greater Than Two Years Post-HSCT Data

<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
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<th>No</th>
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<tbody>
<tr>
<td>30</td>
<td>Other site:</td>
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<tr>
<td>31</td>
<td>Specify:</td>
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<tr>
<td>32</td>
<td>Was specific therapy used to treat acute GVHD since the date of the last report?</td>
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<tr>
<td>33</td>
<td>Specify therapy administered to treat acute GVHD:</td>
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<tr>
<td>34</td>
<td>Specify source:</td>
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<td>35</td>
<td>Specify:</td>
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<td>36</td>
<td>Corticosteroids (systemic)</td>
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<td>37</td>
<td>Corticosteroids (topical)</td>
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<td>38</td>
<td>Cyclosporine (CSA) (Sandimmune, Neoral)</td>
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<td>Anti CD 25 (Zenapax, Daclizumab, AntiTAC)</td>
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<td>Specify:</td>
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<td>44</td>
<td>Campath</td>
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<td>45</td>
<td>Etanercept (Enbrel)</td>
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<td>46</td>
<td>Infliximab (Remicade)</td>
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Form 2300 R3.0: Yearly Follow-up for Greater Than Two Years Post-HSCT Data

47 Other in vivo monoclonal antibody
   [ ] yes  [ ] no

48 Specify: __________________________

49 In vivo immunotoxin
   [ ] yes  [ ] no

50 Specify: __________________________

51 Methotrexate (MTX) (Amethopterin)
   [ ] yes  [ ] no

52 Mycophenolate mofetil (MMF) (CellCept)
   [ ] yes  [ ] no

53 Sirolimus (Rapamycin, Rapamune)
   [ ] yes  [ ] no

54 Ursodiol
   [ ] yes  [ ] no

55 Blinded randomized trial
   [ ] yes  [ ] no

56 Specify trial agent: __________________________

57 Other agent
   [ ] yes  [ ] no

58 Specify: __________________________

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?
   [ ] Yes
   [ ] No
   [ ] No symptoms, but recipient is receiving treatment
   [ ] Unknown

60 Date of chronic GVHD diagnosis: ___ ___ - ___ ___ Date of chronic GVHD diagnosis was previously reported ______

61 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 GVHD flare (symptoms reactivated within 30 days of drug tapering or discontinuation)
Select the phrase in the Karnofsky/Lansky-Play Performance Scale which best describes the activity status of the recipient.

Karnofsky / Lansky score at diagnosis of chronic GVHD:

Platelet count at diagnosis of chronic GVHD: \( \text{______} \times 10^9 / \text{L} \) (\( \times 10^3 \text{mm}^3 \))

Diagnosis was based on:
- histologic evidence / biopsy proven
- Clinical evidence
- Both
- Unknown

Maximum grade of chronic GVHD:
- limited – localized skin involvement and/or hepatic dysfunction due to chronic GVHD
- 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

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
Indicate if there was organ involvement with chronic GVHD:

Sclerosis of skin
- yes
- no

Was involvement proven by biopsy?
- yes
- no

Other skin or hair involvement (rash, ulcers, pruritus or itching, dyspigmentation, alopecia, pruritus changes, etc.)
- yes
- no

Was involvement proven by biopsy?
- yes
- no
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<th>Sequence Number:</th>
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### Eyes
(xerophthalmia (dry eyes), abnormal Schirmer's test, abnormal slit lamp, corneal erosion / conjunctivitis, etc.)
- **71** Eyes: [ ] yes [ ] no
- **72** Was involvement proven by biopsy? [ ] yes [ ] no

### Mouth
(lichenoid changes, mucositis / ulcers, erythema, etc.)
- **73** Mouth: [ ] yes [ ] no
- **74** Was involvement proven by biopsy? [ ] yes [ ] no

### Bronchiolitis Obliterans
- **75** Bronchiolitis obliterans: [ ] yes [ ] no
- **76** Was involvement proven by biopsy? [ ] yes [ ] no

### Other Lung Involvement
- **77** Other lung involvement: [ ] yes [ ] no
- **78** Was involvement proven by biopsy? [ ] yes [ ] no

### Gastrointestinal Tract
(esophageal involvement, chronic nausea / vomiting, chronic diarrhea, malabsorption, abdominal pain / cramps, etc.)
- **79** Gastrointestinal tract: [ ] yes [ ] no
- **80** Was involvement proven by biopsy? [ ] yes [ ] no

### Liver
- **81** Liver: [ ] yes [ ] no
- **82** Was involvement proven by biopsy? [ ] yes [ ] no

### Genitourinary Tract
(vaginitis / stricture, etc.)
- **83** Genitourinary tract: [ ] yes [ ] no
- **84** Was involvement proven by biopsy? [ ] yes [ ] no

### Musculoskeletal
(arthritis, contractures, myositis, myasthenia, etc.)
- **85** Musculoskeletal: [ ] yes [ ] no
- **86** Was involvement proven by biopsy? [ ] yes [ ] no

### Thrombocytopenia
(< 100 x 10^9/L)
- **87** Thrombocytopenia: [ ] yes [ ] no
88 Eosinophilia
   yes  no

89 Autoantibodies
   yes  no

90 Other hematologic involvement
   yes  no

91 Serositis
   yes  no

92 Was involvement proven by biopsy?
   yes  no

93 Weight loss
   yes  no

94 Other organ involvement from chronic GVHD
   yes  no

95 Was involvement proven by biopsy?
   yes  no

96 Specify site: __________________________

97 Was specific therapy used to treat chronic GVHD?
   yes  no

   Specify therapy:

98 ALS, ALG, ATS, ATG
   yes  no

99 Specify source:
   Horse  Rabbit  Other

100 Specify: __________________________

101 Azathioprine
   yes  no

102 Corticosteroids (systemic)
   yes  no

103 Corticosteroids (topical)
   yes  no

104 Cyclosporine (CSA) (Sandimmune, Neoral)
   yes  no
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<tr>
<th></th>
<th>Description</th>
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<td>ECP (extracorporeal photopheresis)</td>
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<td>Etretinate</td>
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<td>115</td>
<td>Lamprne (Clofazimine)</td>
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<td>116</td>
<td>Mycophenolate mofetil (MMF) (CellCept)</td>
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<td>117</td>
<td>Pentostatin</td>
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<td>118</td>
<td>PUVA (Psoralen and UVA)</td>
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<tr>
<td>119</td>
<td>Sirolimus (Rapamycin, Rapamune)</td>
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</tbody>
</table>
122 Thalidomide
   yes  no

123 Ursodiol
   yes  no

124 Blinded randomized trial
   yes  no

125 Specify trial agent: ________________________

126 Other agent:
   yes  no

127 Specify other agent: ________________________

128 Are symptoms of chronic GVHD still present on the date of actual contact (or present at the time of death)?
   yes  no

129 Is the recipient still taking immunosuppressive agents (including PUVA) to treat or prevent GVHD?
   yes  no  Unknown

130 Date final treatment administered: _____ _____ _____
   Date unknown
   Date previously reported

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?
   yes  no

132 For all new malignancies except for "other skin malignancy (basal cell, squamous)," was testing performed to determine the cell of origin?
   Yes
   No

   the only new malignancy in this reporting period was "other skin malignancy (basal cell, squamous)"

133 Specify the cell origin of the new malignancy:
   recipient (host)  donor  origin unknown

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

Specify which new disease(s) occurred:

135 Acute myeloid leukemia (AML / ANLL)
   yes  no

136 Date of diagnosis: _____ _____ _____

137 Other leukemia, including ALL
   yes  no
### Form 2300 R3.0: Yearly Follow-up for Greater Than Two Years Post-HSCT Data

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<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>138 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
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<tr>
<td>139 Specify other leukemia:</td>
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<tr>
<td>140 Breast cancer</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>141 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
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<tr>
<td>142 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)</td>
<td>yes</td>
<td>no</td>
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<td>143 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
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<tr>
<td>144 Clonal cytogenetic abnormality without leukemia or MDS</td>
<td>yes</td>
<td>no</td>
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<td>145 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
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<tr>
<td>146 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>147 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
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<tr>
<td>148 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)</td>
<td>yes</td>
<td>no</td>
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<tr>
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<td>150 Hodgkin disease</td>
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<td>152 Lung cancer</td>
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</tr>
<tr>
<td>154 Lymphoma or lymphoproliferative disease</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>155 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
<td></td>
<td></td>
</tr>
<tr>
<td>156 Is the tumor EBV positive?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>157 Melanoma</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>158 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
<td></td>
<td></td>
</tr>
<tr>
<td>159 Other skin malignancy (basal cell, squamous)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>160 Date of diagnosis: __ __ __ __ - __ __- __ __</td>
<td></td>
<td></td>
</tr>
<tr>
<td>161 Specify other skin malignancy:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Myelodysplasia (MDS) / myeloproliferative (MPS) disorder

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 162 | yes
| 163 | Date of diagnosis: ___ ___ ___ ___ |

### Oropharyngeal cancer (tongue, buccal mucosa)

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 164 | yes
| 165 | Date of diagnosis: ___ ___ ___ ___ |

### Sarcoma

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 166 | yes
| 167 | Date of diagnosis: ___ ___ ___ ___ |

### Thyroid cancer

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 168 | yes
| 169 | Date of diagnosis: ___ ___ ___ ___ |

### Other new malignancy

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 170 | yes
| 171 | Date of diagnosis: ___ ___ ___ ___ |

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
</table>
| 173 | yes

### Other Organ Impairment/Disorder

<table>
<thead>
<tr>
<th>Question</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>174</td>
<td>Has the recipient developed any other clinically significant organ impairment or disorder since the date of last report?</td>
</tr>
<tr>
<td>175</td>
<td>avascular necrosis</td>
</tr>
<tr>
<td>176</td>
<td>Date of diagnosis: ___ ___ ___ ___</td>
</tr>
<tr>
<td>177</td>
<td>bronchiolitis obliterans (BO)</td>
</tr>
<tr>
<td>178</td>
<td>Date of diagnosis: ___ ___ ___ ___</td>
</tr>
<tr>
<td>179</td>
<td>cataracts</td>
</tr>
<tr>
<td>180</td>
<td>Date of diagnosis: ___ ___ ___ ___</td>
</tr>
<tr>
<td>181</td>
<td>congestive heart failure (EF &lt; 40%)</td>
</tr>
<tr>
<td>182</td>
<td>Date of diagnosis: ___ ___ ___ ___</td>
</tr>
<tr>
<td>183</td>
<td>cryptogenic organizing pneumonia (COP)</td>
</tr>
</tbody>
</table>
| 184 | yes
| 185 | no |

Specify impairment/disorder:
Date of diagnosis: __ __ __ __ - __ __ - __ __

184 diabetes / hyperglycemia
   yes  yes  no

185 Date of diagnosis: __ __ __ __ - __ __ - __ __

186 gonadal dysfunction / infertility requiring hormone replacement (testosterone or estrogen)
   yes  no

187 Date of diagnosis: __ __ __ __ - __ __ - __ __

188 growth hormone deficiency / growth disturbance
   yes  no

189 Date of diagnosis: __ __ __ __ - __ __ - __ __

190 hemorraghic cystitis / hematuria requiring medical intervention (catheterization of bladder, extra transfusions, urology consult)
   yes  no

191 Date of diagnosis: __ __ __ __ - __ __ - __ __

192 hypothyroidism
   yes  no

193 Date of diagnosis: __ __ __ __ - __ __ - __ __

194 interstitial pneumonitis (IPn)/ARDS
   yes  no

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

196 myocardial infarction
   yes  no

197 Date of diagnosis: __ __ __ __ - __ __ - __ __

198 non-infectious liver toxicity
   yes  no

199 Date of diagnosis: __ __ __ __ - __ __ - __ __

200 pancreaticitis
   yes  no

201 Date of diagnosis: __ __ __ __ - __ __ - __ __

202 post-transplant microangiopathy-thrombotic thrombocytopenic purpura (TTP), hemolytic uremic syndrome (HUS), or similar syndrome
   yes  no

203 Date of diagnosis: __ __ __ __ - __ __ - __ __

204 Did the recipient receive plasmapheresis?
   yes  no

205 Date of diagnosis: __ __ __ __ - __ __ - __ __

206 pulmonary hemorrhage
   yes  no

207 Date of diagnosis: __ __ __ __ - __ __ - __ __
208 renal failure severe enough to warrant dialysis

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

209 Date of diagnosis: __ __ __ __

210 Did the recipient receive dialysis?

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

211 stroke / seizure

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

212 Date of diagnosis: __ __ __ __

213 Other

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

214 Date of diagnosis: __ __ __ __

215 Specify impairment / disorder: __________________________

<table>
<thead>
<tr>
<th>Subsequent HSCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions: 216 - 223</td>
</tr>
</tbody>
</table>

216 Date of subsequent HSCT: __ __ __ __

217 Was the subsequent HSCT performed at a different institution?

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

Specify the institution that performed the subsequent HSCT:

218 Name: __________________________

219 What was the indication for subsequent HSCT?

| no hematopoietic recovery |
| partial hematopoietic recovery |
| graft failure / rejection after achieving initial hematopoietic recovery |
| persistent primary disease |
| recurrent primary disease |
| Planned second HSCT, per protocol |
| new malignancy |
| stable, mixed chimerism |
| declining chimerism |
| Other |

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

Specify other indication: __________________________

<table>
<thead>
<tr>
<th>Source of HSCs: (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions: 221 - 223</td>
</tr>
</tbody>
</table>

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.

CIBMTR Form 2300 revision 3 last updated January 2010 Copyright(c) 2012 National Marrow Donor Program and The Medical College of Wisconsin, Inc. All rights reserved.
### Donor Cellular Infusion (DCI) Information

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>221 Source of HSCs:</td>
<td>Allogeneic, related, Allogeneic, unrelated, Autologous</td>
</tr>
<tr>
<td>222 Was the same donor used?</td>
<td>yes, no</td>
</tr>
<tr>
<td>223 Specify:</td>
<td>fresh, original NMDP donor bone marrow, fresh, original non-NMDP donor bone marrow, fresh, new NMDP donor bone marrow, fresh, new non-NMDP donor bone marrow, fresh, original NMDP donor mobilized peripheral blood stem cells, fresh, original non-NMDP donor mobilized peripheral blood stem cells, fresh, new NMDP donor mobilized peripheral blood stem cells, fresh, new non-NMDP donor mobilized peripheral blood stem cells, NMDP cord blood, non-NMDP cord blood, cryopreserved original donor bone marrow, cryopreserved original donor mobilized peripheral blood stem cells</td>
</tr>
<tr>
<td>224 Date the first DCI was given:</td>
<td>__ __ __ __ - __ __</td>
</tr>
<tr>
<td>225 Specify the number of cell infusions given within 10 weeks of the first DCI:</td>
<td></td>
</tr>
<tr>
<td>226 Was the DCI infusion performed at a different institution?</td>
<td>yes, no</td>
</tr>
</tbody>
</table>
| 227 Specify the institution that performed the DCI: | Name: ____________________________
City: ____________________________
State / Country: ____________________________ |
Indication for DCI:
- planned as part of initial HSCT protocol
- treatment for relapsed, persistent or progressive disease
- treatment for B cell lymphoproliferative 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.

229 Molecular
- Positive
- Negative
- not done / unknown

230 Date: __ __ __ __

231 Cytogenetic
- Positive
- Negative
- not done / unknown

232 Date: __ __ __ __

233 clinical evidence / hematologic
- Positive
- Negative
- not done / unknown

234 Date: __ __ __ __

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

236 Date of administration of final chemotherapy dose: __ __ __ __

237 Specify viral organism code: __ __ __ __ __ __ __ __ __ __ __ __ __ __

238 Date documented: __ __ __ __

239 Specify other indication: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __.__
Select the phrase in the Karnofsky/Lansky Scale which best describes the activity status of the recipient

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

 Specify DCI source:

243 collected at the time of PBSC mobilization and collection

| yes | no |

244 negative fraction of CD34 selected PBSC

| yes | no |

245 negative fraction of CD34 selected bone marrow

| yes | no |

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

| yes | no |

247 Date of Apheresis: __ __ __ __ - __ __

248 isolated from a unit(s) of whole blood

| yes | no |

249 Specify number of units: ______________________

250 Were the donor cells collected by leukapheresis?

| yes | no |

251 Date of first leukapheresis: __ __ __ __ - __ __

252 Date of last leukapheresis: __ __ __ __ - __ __

253 Number of leukaphereses: ______________________

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

| yes | no |

Specify treatment(s) given:

255 Growth factors

| yes | no |

Specify agent:

256 G-CSF

| yes | no |

257 GM-CSF

| yes | no |

258 Other agent

| yes | no |

259 Specify: ______________________

260 Other treatment

| yes | no |
261 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.

262 CD3+ cells total cells ________________ x10 Specify exponent: __________________________

Not tested

263 CD4+ cells total cells ________________ x10 Specify exponent: __________________________

Not tested

264 CD8+ cells total cells ________________ x10 Specify exponent: __________________________

Not tested

265 CD34+ cells total cells ________________ x10 Specify exponent: __________________________

Not tested

266 NK cells total cells ________________ x10 Specify exponent: __________________________

Not tested

267 Nucleated cells total cells ________________ x10 Specify exponent: __________________________

Not tested

268 Mesenchymal cells: ________________ x10 Specify exponent: __________________________

Not tested

269 Were dendritic cells infused?

yes no

270 Were fibroblasts infused?

yes no

271 Were any other cell types infused (not including cell types reported in questions 262-268)?

yes no

272 Specify: __________________________

273 Were the cells cryopreserved prior to infusion?

yes no

274 Specify portion cryopreserved:

all cells portion of cells

275 Were the cells manipulated prior to infusion?

yes no

276 Specify portion manipulated:

all cells portion of cells

Specify all methods used to manipulated the cells:

277 ABO incompatibility

yes no
<table>
<thead>
<tr>
<th>Specify method:</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>278 buffy coat preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>279 cell separator (i.e., COBE Spectra)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>280 density gradient separation (i.e., Ficoll)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>281 plasma removal</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>282 sedimentation (i.e., hetastarch)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>283 other</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>284 Specify other methods:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>285 dextran-albumin wash</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>286 ex-vivo expansion</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>287 genetic manipulation (gene transfer / transduction)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>288 volume reduction</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>289 CD34+ selection</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>290 Specify manufacturer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ClinIMACS / CliniMax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isolex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>291 Specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>292 T-cell depletion</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>293 Antibody affinity column</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

Report antibodies used for T-cell depletion at question 305.
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>294</td>
<td>Antibody coated plates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>295</td>
<td>Antibody coated plates and soybean lectin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>296</td>
<td>Antibody + complement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>297</td>
<td>Antibody + toxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>298</td>
<td>Immunomagnetic beads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>299</td>
<td>Elutriation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>CD34 affinity column plus sheep red blood cell rosetting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>301</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>302</td>
<td>Specify other method:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>303</td>
<td>Other cell manipulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>304</td>
<td>Specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>305</td>
<td>Were antibodies used during graft manipulation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specify antibodies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>306</td>
<td>Anti CD2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>307</td>
<td>Anti CD4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>308</td>
<td>anti CD5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>309</td>
<td>anti CD6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>310</td>
<td>anti CD7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>311</td>
<td>anti CD8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>312</td>
<td>anti CD34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>313</td>
<td>anti TCR alpha / beta (T10-B9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>314</td>
<td>OKT-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>315</td>
<td>other CD3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>316</td>
<td>Specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>317</td>
<td>anti CD52</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specify antibodies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>318</td>
<td>campath-NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>319</td>
<td>campath-1G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>320</td>
<td>campath-1H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>321</td>
<td>other antibody</td>
<td></td>
<td></td>
</tr>
<tr>
<td>322</td>
<td>Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Form 2300 R3.0: Yearly Follow-up for Greater Than Two Years Post-HSCT Data
Center: CRID: