Granulopoiesis / Neutrophil Recovery

1. Did the recipient achieve an initial hematopoietic recovery (ANC ≥ 500/mm³ for three consecutive lab values obtained on different days) since the date of the last report? (check only one)
   - 1/3 yes
   - 2/3 no, recipient’s initial hematopoietic recovery was recorded on a previous report
   - 3/3 no, ANC ≥ 500/mm³ was not achieved*, and there was no evidence of recurrent disease in the bone marrow
   - 4/3 no, ANC ≥ 500/mm³ was not achieved*, and there was documented persistent disease in the bone marrow post-HSCT
   - 5/3 no, recipient’s ANC never dropped below 500/mm³ at any time after the start of the preparative regimen

2. Date ANC ≥ 500/mm³ (first of 3 lab values): *
   - Month
   - Day
   - Year

3. Following the initial hematopoietic recovery (ANC ≥ 500/mm³ for three consecutive lab values obtained on different days), did the recipient experience a subsequent decline in ANC to < 500/mm³ for ≥ 3 days since the date of the last report?
   - 1/3 yes
   - 2/3 no

4. Date of decline in ANC to < 500/mm³ for ≥ 3 days (first of 3 days that ANC declined): (If multiple declines in ANC occurred during the reporting period, report the date of the first decline.)
   - Month
   - Day
   - Year

   Actual CBC on first day of decline:
   - WBC:
   - Neutrophils:

5. WBC: 1 x 10⁹/L (x 10³/mm³) 2 x 10⁹/L

6. Neutrophils: %

Information reported on this form should cover the time period from the last report submitted until the current time. For example, if the last report was completed at Day 100, and a 9-Year follow-up is now due, the reporting period is from Day 100 until the date of contact for the 9-Year follow-up.

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

Continue with megakaryopoiesis / platelet recovery section at question 11
Megakaryopoiesis / Platelet Recovery

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

11. Was an initial platelet count of ≥ 20 x 10^9/L achieved since the date of the last report?

1 □ yes
2 □ no

12. Date platelets ≥ 20 x 10^9/L: *

Month Day Year □ date estimated □ date unknown

Continue with chimerism section at question 15

13. Was an initial platelet count of ≥ 50 x 10^9/L achieved since the date of the last report?

1 □ yes
2 □ no

14. Date platelets ≥ 50 x 10^9/L: *

Month Day Year □ date estimated □ date unknown

Continue with chimerism section at question 15

Chimerism Studies

This section relates to chimerisms from allogeneic HSCTs only. If this was an autologous HSCT, continue with the signature lines at question 139.

15. Allogeneic HSCTs only: Were chimerism studies performed since the date of the last report?

1 □ yes
2 □ no

16. Are chimerism laboratory reports attached to this form?

1 □ yes
2 □ no

17. Were infusions from more than one donor given?

1 □ yes
2 □ no

Continue with chimerism studies for multiple donors at question 99

18. Specify donor gender:

1 □ male
2 □ female

Continue with chimerism studies for single donor at question 19

Continue with the signature lines at question 139

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
Chimerism Studies (Provide date(s), method(s) and other information for all chimerism studies performed prior to date of contact.)

Valid Method Codes
1. Conventional (standard) cytogenetics
2. Fluorescent in situ hybridization (FISH)
3. Restriction fragment-length polymorphisms (RFLP)
4. HLA typing
5. VNTR or STR, micro or mini satellites
90. Other, specify:

Valid Cell Types
1. Bone marrow (BM)
2. Peripheral blood (PB)
3. T-cells
4. B-cells
5. Monocytes
6. Lymphocytes, not mononuclear cells
7. PMNs (neutrophils)
8. Red blood cells
9. Myeloid cells, not otherwise specified
90. Other, specify:

* If performed by non-quantitative method, indicate the presence of donor or host cells by (+).

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

Sequence Number: __________________________  CIBMTR Recipient ID: __________________________

Today's Date: ____________________________  Infusion Date: ____________________________
Month  Day  Year  Month  Day  Year

CIBMTR Center Number: __________________________  CIBMTR Recipient ID: __________________________

Initials: __________________________

139. Signed: __________________________

Person completing form

Please print name: __________________________

Phone: (_________) __________________________

Fax: (_________) __________________________

E-mail address: __________________________

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