CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Pre-Transplant Essential Data

CIBMTR Use Only
Sequence Number:

Date Received:

OMB No: 0915-0310
Expiration Date: 10/31/2022

The purpose of the data collection is to fulfill the legislative mandate to establish and maintain a standardized database of allogeneic marrow and cord blood transplants performed in the United States or using a donor from the United States. The data collected also meets the C.W. Bill Young Cell Transplantation Program requirements to provide relevant scientific information not containing individually identifiable information available to the public in the form of summaries and data sets. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0310 and it is valid until 10/31/2022. This information collection is voluntary under The Stem Cell Therapeutic and Research Act of 2005, Public Law (Pub. L.) 109–129, as amended by the Stem Cell Therapeutic and Research Reauthorization Act of 2010, Public Law 111–264 (the Act) and the Stem Cell Therapeutic and Research Reauthorization Act of 2015, Public Law 114-104. Public reporting burden for this collection of information is estimated to average 0.68 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

Center Identification

CIBMTR Center Number: ___ ___ ___ ___ ___

EBMT Code (CIC): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Recipient Identification

CIBMTR Research ID (CRID): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Event date: __ __ __ __ / __ __ / __ __
YYYY MM DD

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Recipient Information

1. Date of birth: __ __ __ __ / __ __ / __ __
   YYYY MM DD

2. Sex ☐ Male ☐ Female

3. Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not applicable **(not a resident of the USA)** ☐ Unknown

4. Race **(check all that apply)**
   - ☐ White →
   - ☐ Black or African American →
   - ☐ Asian →
   - ☐ American Indian or Alaska Native →
   - ☐ Native Hawaiian or Other Pacific Islander →
   - ☐ Not reported ***- Go to question 6***
   - ☐ Unknown ***- Go to question 6***

5. Race detail **(check all that apply)**
   - ☐ Eastern European
   - ☐ Mediterranean
   - ☐ Middle Eastern
   - ☐ North Coast of Africa
   - ☐ North American
   - ☐ Northern European
   - ☐ Western European
   - ☐ White Caribbean
   - ☐ White South or Central American
   - ☐ Other White
   - ☐ African
   - ☐ African American
   - ☐ Black Caribbean
   - ☐ Black South or Central American
   - ☐ Other Black
   - ☐ Alaskan Native or Aleut
   - ☐ North American Indian
   - ☐ American Indian, South or Central America
   - ☐ Caribbean Indian
   - ☐ South Asian
   - ☐ Filipino (Pilipino)
   - ☐ Japanese
   - ☐ Korean
   - ☐ Chinese
   - ☐ Vietnamese
   - ☐ Other Southeast Asian
   - ☐ Guamanian
   - ☐ Hawaiian
   - ☐ Samoan
   - ☐ Other Pacific Islander
   - ☐ Unknown

6. Country of primary residence

- ☐ Afghanistan
- ☐ Aland Islands
- ☐ Albania
- ☐ Algeria
- ☐ American Samoa
- ☐ Andorra
- ☐ Angola
- ☐ Anguilla
- ☐ Antarctica
- ☐ Antigua and Barbuda
- ☐ Argentina
- ☐ Armenia
- ☐ Aruba
- ☐ Australia
- ☐ Austria
- ☐ Azerbaijan
- ☐ Bahamas
- ☐ Bahrain
- ☐ Bangladesh
- ☐ Barbados
- ☐ Belarus
- ☐ Belgium
- ☐ Belize
- ☐ Benin
- ☐ Bermuda
- ☐ Bhutan
- ☐ Bolivia
- ☐ Bonaire, Sint Eustatius and Saba
- ☐ Bosnia and Herzegovina
- ☐ Botswana
- ☐ Bouvet Island
- ☐ Brazil ***- go to question 7***
- ☐ British Indian Ocean Territory
- ☐ British Virgin Islands
- ☐ Brunei Darussalam
- ☐ Bulgaria
- ☐ Burkina Faso
- ☐ Burundi
- ☐ Cambodia
- ☐ Cameroon
- ☐ Canada ***- go to question 8***
- ☐ Cape Verde
- ☐ Cayman Islands
- ☐ Central African Republic
- ☐ Chad
- ☐ Chile
- ☐ China
- ☐ Christmas Island
- ☐ Cocos (Keeling) Islands
- ☐ Colombia
- ☐ Comoros
- ☐ Congo, Democratic Republic of the
- ☐ Congo, Republic of the
- ☐ Cook Islands
- ☐ Costa Rica
- ☐ Cote d'Ivoire
- ☐ Croatia
- ☐ Cuba
- ☐ Curacao
- ☐ Cyprus
- ☐ Czech Republic
- ☐ Denmark
- ☐ Djibouti
- ☐ Dominica
- ☐ Dominican Republic
- ☐ Ecuador
- ☐ Egypt
- ☐ El Salvador
- ☐ Equatorial Guinea
- ☐ Eritrea
- ☐ Estonia
- ☐ Ethiopia
- ☐ Falkland Islands
- ☐ Faroe Islands
- ☐ Fiji
- ☐ Finland
- ☐ France
- ☐ French Guiana
- ☐ French Polynesia
- ☐ French Southern Territories
- ☐ Gabon
- ☐ Gambia
- ☐ Georgia
- ☐ Germany
- ☐ Ghana
- ☐ Gibraltar
- ☐ Greece
- ☐ Greenland
- ☐ Grenada
- ☐ Guadeloupe
- ☐ Guam
- ☐ Guatemala
- ☐ Guernsey
- ☐ Guinea
- ☐ Guinea-Bissau
- ☐ Guyana
- ☐ Haiti
- ☐ Heard Island and McDonald Islands
- ☐ Holy See
- ☐ Honduras
- ☐ Hong Kong
- ☐ Hungary
- ☐ Iceland
- ☐ India
- ☐ Indonesia
- ☐ Iran
- ☐ Iraq
- ☐ Ireland
- ☐ Isle of Man
- ☐ Israel
- ☐ Italy
- ☐ Jamaica
- ☐ Japan
- ☐ Jersey
- ☐ Jordan
- ☐ Kazakhstan
- ☐ Kenya
- ☐ Kiribati
- ☐ Kuwait
- ☐ Kyrgyzstan
- ☐ Laos
- ☐ Latvia
- ☐ Lebanon
- ☐ Lesotho
- ☐ Liberia
- ☐ Libya
- ☐ Liechtenstein
- ☐ Lithuania
- ☐ Luxembourg
- ☐ Macau
- ☐ Macedonia
- ☐ Madagascar

- ☐ Malawi
- ☐ Malaysia
- ☐ Maldives
- ☐ Mali
- ☐ Malta
- ☐ Marshall Islands
- ☐ Martinique
- ☐ Mauritania
- ☐ Mauritius
- ☐ Mayotte
- ☐ Mexico
- ☐ Micronesia
- ☐ Moldova
- ☐ Monaco
- ☐ Mongolia
- ☐ Montenegro
- ☐ Montserrat
- ☐ Morocco
- ☐ Mozambique
- ☐ Myanmar
- ☐ Namibia
- ☐ Nauru
- ☐ Nepal
- ☐ Netherlands
- ☐ Netherlands Antilles
- ☐ New Caledonia
- ☐ New Zealand
- ☐ Nicaragua
- ☐ Niger
- ☐ Nigeria
- ☐ Niue
- ☐ Norfolk Island
- ☐ North Korea
- ☐ Northern Mariana Islands
- ☐ Norway
- ☐ Oman
- ☐ Pakistan
- ☐ Palau
- ☐ Palestine, State of
- ☐ Panama
- ☐ Papua New Guinea
- ☐ Paraguay
- ☐ Peru
- ☐ Philippines
- ☐ Pitcairn Islands
- ☐ Poland
- ☐ Portugal
- ☐ Puerto Rico
- ☐ Qatar
- ☐ Reunion
- ☐ Romania
- ☐ Russia
- ☐ Rwanda
- ☐ Saint Barthelemy
- ☐ Saint Helena
- ☐ Saint Kitts and Nevis
- ☐ Saint Lucia
- ☐ Saint Martin, French
- ☐ Saint Pierre and Miquelon
- ☐ Saint Vincent and the Grenadines
- ☐ Samoa
- ☐ San Marino
- ☐ Sao Tome and Principe
- ☐ Saudi Arabia
- ☐ Senegal
- ☐ Serbia
- ☐ Seychelles
- ☐ Sierra Leone
- ☐ Singapore
- ☐ Sint Maarten, Dutch
- ☐ Slovak Republic
- ☐ Slovenia
- ☐ Solomon Islands
- ☐ Somalia
- ☐ South Africa
- ☐ South Georgia and the South Sandwich Islands
- ☐ South Korea
- ☐ South Sudan
- ☐ Spain
- ☐ Sri Lanka
- ☐ Sudan
- ☐ Suriname
- ☐ Svalbard and Jan Mayen
- ☐ Swaziland
- ☐ Sweden
- ☐ Switzerland
- ☐ Syria
- ☐ Taiwan
- ☐ Tajikistan
- ☐ Tanzania
- ☐ Thailand
- ☐ Timor-Leste
- ☐ Togo
- ☐ Tokelau
- ☐ Tonga
- ☐ Trinidad and Tobago
- ☐ Tunisia
- ☐ Turkey
- ☐ Turkmenistan
- ☐ Turks and Caicos Islands
- ☐ Tuvalu
- ☐ Uganda
- ☐ Ukraine
- ☐ United Arab Emirates
- ☐ United Kingdom (England, Wales, Scotland, Northern Ireland)
- ☐ United States ***- go to question 9***
- ☐ United States Minor Outlying Islands
- ☐ United States Virgin Islands
- ☐ Uruguay
- ☐ Uzbekistan
- ☐ Vanuatu
- ☐ Venezuela
- ☐ Vietnam
- ☐ Wallis and Futuna Islands
- ☐ Western Sahara
- ☐ Yemen
- ☐ Zambia
- ☐ Zimbabwe

7. State of residence of recipient **(for residents of Brazil)** - ***Go to question 10***

- ☐ Acre
- ☐ Alagoas
- ☐ Amapá
- ☐ Amazonas
- ☐ Bahia
- ☐ Ceará
- ☐ Distrito Federal
- ☐ Espírito Santo
- ☐ Goiás
- ☐ Maranhão
- ☐ Mato Grosso
- ☐ Mato Grosso do Sul
- ☐ Minas Gerais
- ☐ Pará
- ☐ Paraná
- ☐ Paraíba
- ☐ Pernambuco
- ☐ Piauí
- ☐ Rio de Janeiro
- ☐ Rio Grande do Norte
- ☐ Rio Grande do Sul
- ☐ Rondônia
- ☐ Roraima
- ☐ Santa Catarina
- ☐ São Paulo
- ☐ Sergipe
- ☐ Tocantins

8. Province or territory of residence of recipient **(for residents of Canada)** - ***Go to question 10***

Provinces

- ☐ Alberta
- ☐ British Columbia
- ☐ Quebec
- ☐ Manitoba
- ☐ New Brunswick
- ☐ Newfoundland and Labrador
- ☐ Nova Scotia
- ☐ Ontario
- ☐ Prince Edward Island
- ☐ Quebec
- ☐ Saskatchewan

Territories

- ☐ Northwest Territories
- ☐ Nunavut
- ☐ Yukon

9. State of residence of recipient **(for residents of USA)**

- ☐ Alabama
- ☐ Alaska
- ☐ Arizona
- ☐ Arkansas
- ☐ California
- ☐ Colorado
- ☐ Connecticut
- ☐ Delaware
- ☐ District of Columbia
- ☐ Florida
- ☐ Georgia
- ☐ Hawaii
- ☐ Idaho
- ☐ Illinois
- ☐ Indiana
- ☐ Iowa
- ☐ Kansas
- ☐ Kentucky
- ☐ Louisiana
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ Michigan
- ☐ Minnesota
- ☐ Mississippi
- ☐ Missouri
- ☐ Montana
- ☐ Nebraska
- ☐ Nevada
- ☐ New Hampshire
- ☐ New Jersey
- ☐ New Mexico
- ☐ New York
- ☐ North Carolina
- ☐ North Dakota
- ☐ Ohio
- ☐ Oklahoma
- ☐ Oregon
- ☐ Pennsylvania
- ☐ Rhode Island
- ☐ South Carolina
- ☐ South Dakota
- ☐ Tennessee
- ☐ Texas
- ☐ Utah
- ☐ Vermont
- ☐ Virginia
- ☐ Washington
- ☐ West Virginia
- ☐ Wisconsin
- ☐ Wyoming

10. NMDP Recipient ID (RID): __ __ __ __ __ __ __

11. Zip or postal code for place of recipient's residence **(USA recipients only)**: ___ ___ ___ ___ ___ - ___ ___ ___ ___ (last 4 digits optional)

12. Specify blood type **(of recipient) (For allogeneic HCTs only)** ☐ A ☐ B ☐ AB ☐ O

13. Specify Rh factor **(of recipient) (For allogeneic HCTs only)** ☐ Positive ☐ Negative

14. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form for submitting research data to the NMDP / CIBMTR?

☐ Yes **(recipient consented)** →
☐ No **(recipient declined)**
☐ Not approached

15. Did the recipient give permission to be directly contacted by CIBMTR for future research?
☐ Yes **(recipient provided permission)** ☐ No **(recipient declined)**

16. Date form was signed: __ __ __ __ / __ __ / __ __
YYYY MM DD

17. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR? **(For allogeneic HCTs only)**

☐ Yes **(recipient consented)** →
☐ No **(recipient declined)**
☐ Not approached
☐ Not applicable **(center not participating)**

18. Date form was signed: __ __ __ __ / __ __ / __ __
YYYY MM DD

19. Did the recipient submit a research sample to the NMDP/CIBMTR repository? **(Related donors only)**
☐ Yes →
☐ No

20. Research sample recipient ID:
___ ___ ___ ___ ___ ___ ___ ___ ___ ___

21. Is the recipient participating in a clinical trial? **(clinical trial sponsors that uses CIBMTR forms to capture outcomes data)**

☐ Yes →
☐ No

22. Study Sponsor
☐ BMT-CTN ***- Go to question 24***
☐ RCI-BMT ***- Go to question 24***
☐ PIDTC ***- Go to question 24***
☐ USIDNET ***- Go to question 25***
☐ COG ***- Go to question 25***
☐ Other sponsor ***- Go to question 23***

23. Specify other sponsor: _____
- Go to question 25

24. Study ID Number: _____

25. Subject ID: _____

Copy questions 22 - 25 to report participation in more than one study.

Hematopoietic Cellular Transplant (HCT) and Cellular Therapy

26. Is a subsequent HCT planned as part of the overall treatment protocol? **(not as a reaction to post-HCT disease assessment) (For autologous HCTs only)**
- ☐ Yes →
- ☐ No

27. Specify subsequent HCT planned ☐ Autologous ☐ Allogeneic

28. Has the recipient ever had a prior HCT?
- ☐ Yes →
- ☐ No

29. Specify the number of prior HCTs: ___ ___

30. Were all prior HCTs reported to the CIBMTR? ☐ Yes ☐ No ☐ Unknown

Copy and complete questions 31 - 34 to report all prior HCTs that have not yet been reported to the CIBMTR

31. Date of the prior HCT: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD) ☐ Date estimated

32. Was the prior HCT performed at a different institution?
- ☐ Yes →
- ☐ No

Specify the institution that performed the last HCT

33. Name: _____
City: _____
State: _____
Country: _____

34. What was the HPC source for the prior HCT? **(check all that apply)**
☐ Autologous ☐ Allogeneic, unrelated ☐ Allogeneic, related

35. Reason for current HCT
- ☐ Graft failure / insufficient hematopoietic recovery ***- Go to question 36***
- ☐ Persistent primary disease ***- Go to question 40***
- ☐ Recurrent primary disease ***- Go to question 37***
- ☐ Planned subsequent HCT, per protocol ***- Go to question 40***
- ☐ New malignancy **(including PTLD and EBV lymphoma)** ***- Go to question 38***
- ☐ Insufficient chimerism ***- Go to question 40***
- ☐ Other ***- Go to question 39***

36. Date of graft failure / rejection: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- Go to question 40

37. Date of relapse: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- Go to question 40

38. Date of secondary malignancy: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- Go to question 40

39. Specify other reason: _____

40. Has the recipient ever had a prior cellular therapy? **(do not include DLIs)**
- ☐ Yes →
- ☐ No
- ☐ Unknown

41. Were all prior cellular therapies reported to the CIBMTR?
- ☐ Yes
- ☐ No →
- ☐ Unknown ***- Go to question 46***

Copy and complete questions 42 - 45 to report all prior cellular therapies that have not yet been reported to the CIBMTR

42. Date of the prior cellular therapy: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)

43. Was the cellular therapy performed at a different institution?
- ☐ Yes →
- ☐ No

44. Name: _____
City: _____
State: _____
Country: _____

45. Specify the source(s) for the prior cellular therapy **(check all that apply)**
☐ Autologous ☐ Allogeneic, unrelated ☐ Allogeneic, related

Donor Information

46. Multiple donors?
- ☐ Yes →
- ☐ No

47. Specify number of donors: ___ ___

To report more than one donor, copy questions 48 - 83 and complete for each donor.

48. Specify donor ☐ Autologous ☐ Allogeneic, related ☐ Allogeneic, unrelated

49. Specify product type **(check all that apply)**
- ☐ Bone marrow
- ☐ PBSC
- ☐ Single cord blood unit
- ☐ Other product →

50. Specify other product type: _____

51. Is the product genetically modified? ☐ Yes ☐ No
If autologous, go to question 80.
If allogeneic related, go to question 52.
If allogeneic unrelated, go to question 56.

52. Specify the related donor type
- ☐ Syngeneic **(monozygotic twin)** ***- Go to question 57***
- ☐ HLA-identical sibling **(may include non-monozygotic twin)** ***- Go to question 57***
- ☐ HLA-matched other relative **(does NOT include a haplo-identical donor)** ***- Go to question 53***
- ☐ HLA-mismatched relative ***- Go to question 53***

53. Specify the biological relationship of the donor to the recipient

- ☐ Mother
- ☐ Father
- ☐ Child
- ☐ Sibling
- ☐ Fraternal twin
- ☐ Maternal aunt
- ☐ Maternal uncle
- ☐ Maternal cousin
- ☐ Paternal aunt
- ☐ Paternal uncle
- ☐ Paternal cousin
- ☐ Grandparent
- ☐ Grandchild
- ☐ Other biological relative →

54. Specify other biological relative:

_____

55. Degree of mismatch **(related donor only)**

- ☐ HLA-mismatched 1 allele ***- Go to question 57***
- ☐ HLA-mismatched ≥2 alleles **(does include haplo-identical donor)** ***- Go to question 57***

56. Specify unrelated donor type ☐ HLA matched unrelated ☐ HLA mismatched unrelated

57. Did NMDP/Be the Match facilitate the procurement, collections, or transportation of the product?

☐ Yes ☐ No

58. Was this donor used for any prior HCTs? **(for this recipient)** ☐ Yes ☐ No

59. NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ***- Go to question 63***

61. Non-NMDP unrelated donor ID: **(not applicable for related donors)** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
- Go to question 63

62. Non-NMDP cord blood unit ID: **(include related and autologous CBUs)** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
- Go to question 63

63. Global Registration Identifier for Donors (GRID): __
NMDP cord blood unit, go to question 75
NMDP donor, go to question 75
Non-NMDP unrelated donor, go to question 66
Non-NMDP cord blood unit, go to question 64

64. Is the CBU ID also the ISBT DIN number?

- ☐ Yes
- ☐ No →
- ☐ Unknown

65. Specify the ISBT DIN number:_____

66. Registry or UCB Bank ID: ___ ___ ___ ___ ***- If 'Other registry' go to 67, otherwise go to question 68***

67. Specify other Registry or UCB Bank:_____

68. Date of birth **(donor / infant)**

☐ Known →

69. Date of birth: **(donor / infant)** __ __ __ __ / __ __ / __ __ ***- Go to question 72***
YYYY MM DD

☐ Unknown →

70. Age **(donor / infant)**

☐ Known →

71. Age: **(donor / infant)** ___ ___ ☐ Months (use only if less than 1 year old) ☐ Years

☐ Unknown

72. Sex **(donor / infant)** ☐ Male ☐ Female

73. Specify blood type **(donor) (non-NMDP allogeneic donors only)** ☐ A ☐ B ☐ AB ☐ O

74. Specify Rh factor **(donor) (non-NMDP allogeneic donors only)** ☐ Positive ☐ Negative

75. Donor CMV-antibodies **(IgG or Total) (Allogeneic HCTs only)**

☐ Reactive ☐ Non-reactive ☐ Indeterminant ☐ Not done ☐ Not applicable **(cord blood unit)**

76. Has the donor signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR? **(Related donors only)**

☐ Yes **(donor consented)** →

77. Date form was signed: __ __ __ __ / __ __ / __ __
YYYY MM DD

78. Did the donor submit a research sample to the NMDP/CIBMTR repository? **(Related donors only)**

☐ Yes →

79. Research sample donor ID:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ No

☐ No **(donor declined)**

☐ Not approached

☐ Not applicable **(center not participating)**

80. Specify number of products infused from this donor: ___ ___

81. Specify the number of these products intended to achieve hematopoietic engraftment: ___ ___

Questions 82 - 83 are for autologous HCT recipients only. If other than autologous skip to question 84.

82. What agents were used to mobilize the autologous recipient for this HCT? **(check all that apply)**

☐ G-CSF (filgrastim, Neupogen)

☐ Pegylated G-CSF (pegfilgrastim, Neulasta)

☐ Plerixafor (Mozobil)

☐ Combined with chemotherapy

☐ Anti-CD20 (rituximab, Rituxan)

☐ Other agent →

83. Specify other agent: _____

To report more than one donor, copy questions 48 - 83 and complete for each donor.

Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

84. What scale was used to determine the recipient's functional status?

☐ Karnofsky **(recipient age ≥ 16 years)**

Performance score prior to the preparative regimen:

85. Karnofsky Scale **(recipient age ≥ 16 years)**

- ☐ 100 Normal; no complaints; no evidence of disease
- ☐ 90 Able to carry on normal activity
- ☐ 80 Normal activity with effort
- ☐ 70 Cares for self; unable to carry on normal activity or to do active work
- ☐ 60 Requires occasional assistance but is able to care for most needs
- ☐ 50 Requires considerable assistance and frequent medical care
- ☐ 40 Disabled; requires special care and assistance
- ☐ 30 Severely disabled; hospitalization indicated, although death not imminent
- ☐ 20 Very sick; hospitalization necessary
- ☐ 10 Moribund; fatal process progressing rapidly.

☐ Lansky **(recipient age ≥ 1 year and < 16 years)**

86. Lansky Scale **(recipient age ≥ 1 year and < 16 years)**

- ☐ 100 Fully active
- ☐ 90 Minor restriction in physically strenuous play
- ☐ 80 Restricted in strenuous play, tires more easily, otherwise active
- ☐ 70 Both greater restrictions of, and less time spent in, active play
- ☐ 60 Ambulatory up to 50% of time, limited active play with assistance/supervision
- ☐ 50 Considerable assistance required for any active play; fully able to engage in quiet play
- ☐ 40 Able to initiate quiet activities
- ☐ 30 Needs considerable assistance for quiet activity
- ☐ 20 Limited to very passive activity initiated by others (e.g., TV)
- ☐ 10 Completely disabled, not even passive play

87. Recipient CMV-antibodies **(IgG or Total)**

☐ Reactive ☐ Non-reactive ☐ Indeterminant ☐ Not done

Co-morbid Conditions

88. Has the patient been infected with COVID-19 (SARS-CoV-2) based on a positive test result at any time prior to the start of the preparative regimen / infusion?

☐ Yes → 89. Did the patient require hospitalization for management of COVID-19 (SARS-CoV-2) infection?

☐ No

☐ Yes → 90. Was mechanical ventilation given for COVID-19 (SARS-CoV-2) infection?

☐ Yes ☐ No

☐ No

91. Is there a history of mechanical ventilation **(excluding COVID-19 (SARS-CoV-2)**? ☐ Yes ☐ No

92. Is there a history of invasive fungal infection? ☐ Yes ☐ No

93. Glomerular filtration rate (GFR) before start of preparative regimen **(pediatric only)**

☐ Known → 94. Glomerular filtration rate (GFR): __ __ __ mL/min/1.73^2

☐ Unknown

95. Does the recipient have known complex congenital heart disease? **(corrected or uncorrected) (excluding simple ASD, VSD, or PDA repair) (pediatric only)**

☐ Yes ☐ No

96. Were there any co-existing diseases or organ impairment present according to the HCT comorbidity index (HCT-CI)? **(Source: Sorror, M. L. (2013). How I assess comorbidities before hematopoietic cell transplantation. Blood, 121(15), 2854-2863.)**

☐ Yes →

☐ No

97. Specify co-existing diseases or organ impairment **(check all that apply)**

- ☐ Arrhythmia **– Any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment**
- ☐ Cardiac **– Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test**
- ☐ Cerebrovascular disease **– Any history of transient ischemic attack, subarachnoid hemorrhage or cerebral thrombosis, embolism, or hemorrhage**
- ☐ Diabetes **– Requiring treatment with insulin or oral hypoglycemic drugs in the last 4 weeks but not diet alone**
- ☐ Heart valve disease **– At least a moderate to severe degree of valve stenosis or insufficiency as determined by Echo; prosthetic mitral or aortic valve; or symptomatic mitral valve prolapse**
- ☐ Hepatic, mild **– bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection**
- ☐ Hepatic, moderate/severe **– Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal**
- ☐ Infection **– Includes a documented infection, fever of unknown origin, or pulmonary nodules suspicious for fungal pneumonia or a positive PPD test requiring prophylaxis against tuberculosis. Patients must have started antimicrobial treatment before Day 0 with continuation of antimicrobial treatment after day 0**
- ☐ Inflammatory bowel disease **– Any history of Crohn's disease or ulcerative colitis requiring treatment**
- ☐ Obesity **– Patients older than 18 years with a body mass index (BMI) > 35 kg/m^2 prior to the start of conditioning or a BMI of the 95th percentile of higher for patients aged 18 years or younger**
- ☐ Peptic ulcer **– Any history of peptic (gastric or duodenal) ulcer confirmed by endoscopy or radiologic diagnosis requiring treatment**
- ☐ Psychiatric disturbance **– Presence of any mood (e.g., depression), anxiety, or other psychiatric disorder (e.g. bipolar disorder or schizophrenia) requiring continuous treatment in the last 4 weeks**
- ☐ Pulmonary, moderate **– Corrected diffusion capacity of carbon monoxide and/or FEV1 of 66-80% or dyspnea on slight activity attributed to pulmonary disease at transplant**
- ☐ Pulmonary, severe **– Corrected diffusion capacity of carbon monoxide and/or FEV1 of ≤ 65% or dyspnea at rest attributed to pulmonary disease or the need for intermittent or continuous oxygen during the 4 weeks prior to transplant**

☐ Renal, moderate / severe **– Serum creatinine > 2 mg/dL or > 177 µmol/L; on dialysis at during the 4 weeks prior to transplant; OR prior renal transplantation** ***- Go to question 98***

☐ Rheumatologic **– Any history of a rheumatologic disease (e.g., systemic lupus erythematosis, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica, etc.) requiring treatment. (Do NOT include degenerative joint disease, osteoarthritis)**

☐ Prior malignancy **– Treated at any time point in the patient's past history, other than the primary disease for which this infusion is being performed** ***- Go to question 99***

98. Was the recipient on dialysis immediately prior to start of preparative regimen?

☐ Yes ☐ No ☐ Unknown

99. Specify prior malignancy **(check all that apply)**

☐ Breast cancer
☐ Central nervous system (CNS) malignancy **(e.g., glioblastoma, astrocytoma)**
☐ Gastrointestinal malignancy **(e.g., colon, rectum, stomach, pancreas, intestine, esophageal)**
☐ Genitourinary malignancy **(e.g., kidney, bladder, ovary, testicle, genitalia, uterus, cervix, prostate)**
☐ Leukemia **(includes acute or chronic leukemia)**
☐ Lung cancer
☐ Lymphoma **(includes Hodgkin & non-Hodgkin lymphoma)**
☐ MDS / MPN
☐ Melanoma
☐ Multiple myeloma / plasma cell disorder (PCD)
☐ Oropharyngeal cancer **(e.g., tongue, buccal mucosa)**
☐ Sarcoma
☐ Thyroid cancer
☐ Other prior skin malignancy **(basal cell, squamous)** ***- Go to question 100***
☐ Other prior hematologic malignancy ***- Go to question 101***
☐ Other solid tumor ***- Go to question 102***

100. Specify other skin malignancy: (prior) _____

101. Specify other hematologic malignancy: (prior)_____

102. Specify other solid tumor: (prior) _____

Use results within 4 weeks prior to the start of the preparative regimen, report results from the test performed closest to the start date. Biomarkers according to the augmented HCT comorbidity index. (Source: Biol Blood Marrow Transplant. 2015 Aug; 21(8): 1418-1424)

103. Serum ferritin **(within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)**

☐ Known →
☐ Unknown

104. ___ ___ ___ ___ ___ ng/mL (µg/L)

105. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD

106. Upper limit of normal for your institution: ___ ___ ___ ___ ___

107. Serum albumin **(within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)**

☐ Known →
☐ Unknown

108. ___ ___ • ___ ☐ g/dL ☐ g/L

109. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD

110. Platelets **(with 4 weeks prior to the start of the preparative regimen, use result closest to the start date)**

☐ Known →
☐ Unknown

111. ___ ___ ___ ___ ___ ___ ___ ☐ x 10^9/L (x 10^3/mm^3) ☐ x 10^6/L

112. Were platelets transfused ≤ 7 days before date of test?
☐ Yes ☐ No ☐ Unknown

113. Did the recipient have a prior solid organ transplant?

☐ Yes →
☐ No

114. Specify organ:
☐ Bowel
☐ Heart
☐ Kidney(s)
☐ Liver
☐ Lung(s)
☐ Pancreas
☐ Other organ →

115. Specify other organ:_____

116. Year of prior solid organ transplant: ___ ___ ___ ___

Copy and complete questions 114 - 116 for each prior solid organ transplant

Pre-HCT Preparative Regimen (Conditioning)

117. Height at initiation of pre-HCT preparative regimen: ___ ___ ___ ☐ inches ☐ centimeters

118. Actual weight at initiation of pre-HCT preparative regimen: ___ ___ ___ • ___ ☐ pounds ☐ kilograms

119. Was a pre-HCT preparative regimen prescribed?

☐ Yes →
☐ No - ***Go to question 132***

120. Classify the recipient's prescribed preparative regimen **(Allogeneic HCTs only)**
☐ Myeloablative ☐ Non-myeloablative (NST) ☐ Reduced intensity (RIC)

121. Was irradiation planned as part of the pre-HCT preparative regimen?

☐ Yes →
☐ No

122. What was the prescribed radiation field?
☐ Total body
☐ Total body by intensity-modulated radiation therapy (IMRT)
☐ Total lymphoid or nodal regions
☐ Thoracoabdominal region

123. Total prescribed dose: **(dose per fraction x total number of fractions)** ___ ___ ___ • ___ ___ ☐ Gy ☐ cGy

124. Date started: __ __ __ __ / __ __ / __ __
YYYY MM DD

125. Was the radiation fractionated?

☐ Yes → 126. Total number of fractions: ___ ___

☐ No

Indicate the total prescribed cumulative dose for the preparative regimen

127. Drug

- ☐ Bendamustine
- ☐ Busulfan
- ☐ Carboplatin
- ☐ Carmustine (BCNU)
- ☐ CCNU (Lomustine)
- ☐ Clofarabine (Clolar)
- ☐ Cyclophosphamide (Cytoxan)
- ☐ Cytarabine (Ara-C)
- ☐ Etoposide (VP-16, VePesid)
- ☐ Fludarabine
- ☐ Gemcitabine
- ☐ Ibritumomab tiuxetan (Zevalin)
- ☐ Ifosfamide
- ☐ Melphalan (L-Pam)
- ☐ Methylprednisolone (Solu-Medrol)
- ☐ Pentostatin
- ☐ Propylene glycol-free melphalan (Evomela)
- ☐ Rituximab (Rituxan)
- ☐ Thiotepa
- ☐ Tositumomab (Bexxar)
- ☐ Treosulfan
- ☐ Other drug → 128. Specify other drug:_____

129. Total prescribed dose: __ __ __ __ • __

- ☐ mg/m^2
- ☐ mg/kg
- ☐ AUC (mg x h/L)
- ☐ AUC (µmol x min/L)
- ☐ CSS (ng/mL)

130. Date started: __ __ __ __ / __ __ / __ __
YYYY MM DD

131. Specify administration **(busulfan only)** ☐ Oral ☐ IV ☐ Both

Copy and complete question 127 - 131 to report each drug given for the preparative regimen

Additional drugs given in the Peri-Transplant period

132. ALG, ALS, ATG, ATS
- ☐ Yes →
- ☐ No

133. Total prescribed dose: ___ ___ ___ ___ ___ mg/kg

134. Specify source
- ☐ ATGAM (horse)
- ☐ ATG – Fresenius (rabbit)
- ☐ Thymoglobulin (rabbit)
- ☐ Other →

135. Specify other source: _____

136. Alemtuzumab (Campath)
- ☐ Yes →
- ☐ No

137. Total prescribed dose: __ __ __ __ • __ ☐ mg/m² ☐ mg/kg ☐ mg

138. Defibrotide ☐ Yes ☐ No

139. KGF ☐ Yes ☐ No

140. Ursodiol ☐ Yes ☐ No

GVHD Prophylaxis

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 144.

141. Was GVHD prophylaxis planned?
- ☐ Yes →
- ☐ No

142. Specify drugs / intervention **(check all that apply)**
- ☐ Abatacept
- ☐ Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
- ☐ Blinded randomized trial
- ☐ Bortezomib
- ☐ CD34 enriched (CD34+ selection)
- ☐ Corticosteroids (systemic)
- ☐ Cyclophosphamide (Cytoxan)
- ☐ Cyclosporine (CSA, Neoral, Sandimmune)
- ☐ Extra-corporeal photopheresis (ECP)
- ☐ Ex-vivo T-cell depletion
- ☐ Filgotinib
- ☐ Maraviroc
- ☐ Methotrexate (MTX) (Amethopterin)
- ☐ Mycophenolate mofetil (MMF) (CellCept)
- ☐ Ruxolitinib
- ☐ Sirolimus (Rapamycin, Rapamune)
- ☐ Tocilizumab
- ☐ Tacrolimus (FK 506)
- ☐ Other agent →

143. Specify other agent: _____
(do not report ATG, campath)

Post-HCT Disease Therapy Planned as of Day 0

144. Is additional post-HCT therapy planned?

- ☐ Yes →
- ☐ No - ***Go to First Name***

Questions 145 - 146 are optional for non-U.S. centers

145. Specify post-HCT therapy planned **(check all that apply)**

- ☐ Azacytidine (Vidaza)
- ☐ Blinatumomab
- ☐ Bortezomib (Velcade)
- ☐ Bosutinib
- ☐ Brentuximab
- ☐ Carfilzomib
- ☐ Cellular therapy **(e.g. DCI, DLI)**
- ☐ Crenolanib
- ☐ Daratumumab
- ☐ Dasatinib
- ☐ Decitabine
- ☐ Elotuzumab
- ☐ Enasidenib
- ☐ Gilteritinib
- ☐ Ibrutinib
- ☐ Imatinib mesylate (Gleevec, Glivec)
- ☐ Intrathecal therapy **(chemotherapy)**
- ☐ Ivosidenib
- ☐ Ixazomib
- ☐ Lenalidomide (Revlimid)
- ☐ Lestaurtinib
- ☐ Local radiotherapy
- ☐ Midostaurin
- ☐ Nilotinib
- ☐ Obinutuzumab
- ☐ Pacritinib
- ☐ Ponatinib
- ☐ Quizartinib
- ☐ Rituximab (Rituxan, MabThera)
- ☐ Sorafenib
- ☐ Sunitinib
- ☐ Thalidomide (Thalomid)
- ☐ Other therapy → 146. Specify other therapy: _____
- ☐ Unknown

Prior Exposure: Potential Study Eligibility

Selecting any option(s) below may generate an additional supplemental form.

147. Specify if the recipient received any of the following **(at any time prior to HCT / infusion) (check all that apply)**

- ☐ Blinatumomab (Blincyto)
- ☐ Gemtuzumab ozogamicin (Mylotarg)
- ☐ Inotuzumab ozogamicin (Besponsa)
- ☐ Adienne Tepadina®
- ☐ Mogamulizumab (Poteligeo)
- ☐ None of the above

First Name: _____

Last Name:_____

E-mail address: _____

Date: __ __ __ __ / __ __ / __ __
YYYY MM DD