New Malignancy, Lymphoproliferative or Myeloproliferative Disorder

1. Did a new malignancy, lymphoproliferative or myeloproliferative disorder occur? Different from the disease for which HSCT performed (not recurrence or transformation).
   - [ ] yes
   - [ ] no
   - [ ] unknown

2. Date of diagnosis: ___________ ___________ ___________
   Year      Month      Day

3. Specify:
   - [ ] Acute myeloid leukemia (AML / ANLL)
   - [ ] Other leukemia (including ALL)
   - [ ] Breast cancer
   - [ ] Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
   - [ ] Clonal cytogenetic abnormality without leukemia or MDS
   - [ ] Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
   - [ ] Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
   - [ ] Hodgkin disease
   - [ ] Lung cancer
   - [ ] Lymphoma or lymphoproliferative disease
   - [ ] Melanoma
   - [ ] Other skin malignancy (basal cell, squamous)
   - [ ] Myelodysplasia (MDS) / myeloproliferative (MPS) disorder
   - [ ] Oropharyngeal cancer (tongue, buccal mucosa)
   - [ ] Sarcoma
   - [ ] Thyroid cancer
   - [ ] Other malignancy

4. Specify: __________________________

5. Is the tumor EBV positive?
   - [ ] yes
   - [ ] no
   - [ ] unknown

6. Specify: __________________________

7. Copy of pathology report / documentation attached?
   - [ ] yes
   - [ ] no

Note: “> 100 Days Report” answer since last report

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
### Survival
8. **Survival status** at latest follow-up:

<table>
<thead>
<tr>
<th>1</th>
<th>Alive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Dead</td>
</tr>
<tr>
<td>3</td>
<td>Lost To Follow-Up (LTF)</td>
</tr>
</tbody>
</table>

9. Latest follow-up: _Month_ _Day_ _Year_

10. Date of death: _Month_ _Day_ _Year_

11. **Main cause of death** (check only one main cause):

1. Relapse / Progression / Persistent disease
2. HSCT related causes
3. New malignancy
4. Other
5. Unknown

(Check as many as appropriate):
12. 1 [ ] yes 2 [ ] no GVHD
13. 1 [ ] yes 2 [ ] no Cardiac toxicity
14. 1 [ ] yes 2 [ ] no Infection
15. 1 [ ] yes 2 [ ] no Pulmonary toxicity
16. 1 [ ] yes 2 [ ] no Rejection / Poor graft function
17. 1 [ ] yes 2 [ ] no VOD
18. 1 [ ] yes 2 [ ] no Other

19. Specify: ________________

20. Specify: ________________

21. Last known date alive: _Month_ _Day_ _Year_

☐ Day of the month is estimated

Submit Form 2802 — Lost to Follow-Up Declaration

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22. Signed: ____________________________

**Person completing form**

Please print name: ____________________________

Phone: (___________) ____________________________

Fax: (___________) ____________________________

E-mail address: ____________________________

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CIBMTR Form 2455 (post-TED) v1.0 (2–2) January 2008
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