Form 2455 R3.0: Selective Post-Transplant Essential Data

Central Identification

CIBMTR Center Number: ____________________________
EBMT Code (CIC): ____________________________
Date of This Report: __ __ __ __ - __ __- __ __
Follow-Up:
- day 100
- 6 months
- annual
  specify year ____________________________

Recipient Identification

CIBMTR Recipient ID: ____________________________
Chronological number of this: HSCT #: ____________________________
DCI: ____________________________
Date of HSCT for this follow-up: __ __ __ __ - __ __- __ __
Did the recipient receive a subsequent HSCT since the date of contact from the last report?
- yes
- no
  Date of subsequent HSCT: __ __ __ __ - __ __- __ __

New Malignancy

Questions: 1 - 43

1 Did a new malignancy, lymphoproliferative or myeloproliferative disorder appear that is different from the disease for which the HSCT was performed?
  - yes
  - no

2 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)"

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

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

Specify which new disease(s) occurred:

5 Acute myeloid leukemia (AML / ANLL)
  - yes
  - no

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

6 Other leukemia, including ALL
  - yes
  - no

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

7 Specify other leukemia: ____________________________
10 Breast cancer
   yes  no

11 Date of diagnosis: __ __ __ __ - __ __- __ __

12 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
   yes  no

13 Date of diagnosis: __ __ __ __ - __ __- __ __

14 Clonal cytogenetic abnormality without leukemia or MDS
   yes  no

15 Date of diagnosis: __ __ __ __ - __ __- __ __

16 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
   yes  no

17 Date of diagnosis: __ __ __ __ - __ __- __ __

18 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
   yes  no

19 Date of diagnosis: __ __ __ __ - __ __- __ __

20 Hodgkin disease
   yes  no

21 Date of diagnosis: __ __ __ __ - __ __- __ __

22 Lung cancer
   yes  no

23 Date of diagnosis: __ __ __ __ - __ __- __ __

24 Lymphoma or lymphoproliferative disease
   yes  no

25 Date of diagnosis: __ __ __ __ - __ __- __ __

26 Is the tumor EBV positive?
   yes  no  Unknown

27 Melanoma
   yes  no

28 Date of diagnosis: __ __ __ __ - __ __- __ __

29 Other skin malignancy (basal cell, squamous)
   yes  no

30 Date of diagnosis: __ __ __ __ - __ __- __ __

31 Specify other skin malignancy: _______________________

32 Myelodysplasia (MDS) / myeloproliferative (MPS) disorder
   yes  no

33 Date of diagnosis: __ __ __ __ - __ __- __ __
Oropharyngeal cancer (tongue, buccal mucosa)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Date of diagnosis: __ __ __ __ __ __ __ __ ___

Sarcoma

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Date of diagnosis: __ __ __ __ __ __ __ __ ___

Thyroid cancer

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Date of diagnosis: __ __ __ __ __ __ __ __ ___

Other new malignancy

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Date of diagnosis: __ __ __ __ __ __ __ __ ___

Specify other new malignancy:

Is a pathology / autopsy report or other documentation attached?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Survival status at latest follow-up:

<table>
<thead>
<tr>
<th>Alive</th>
<th>Dead</th>
</tr>
</thead>
</table>

Last contact date: __ __ __ __ __ __ __ __ ___ day of the month is estimated

Date of death: __ __ __ __ __ __ __ __ ___ day of the month is estimated

Main cause of death: (check only one)

- relapse/progression/persistent disease
- HSCT related causes
- new malignancy
- Other
- Unknown

Specify HSCT related cause of death: (check as many as appropriate)

- GVHD
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Cardiac toxicity
  | Yes | No |

- Infection
<p>| Yes | No |</p>
<table>
<thead>
<tr>
<th>Form 2455 R3.0: Selective Post-Transplant Essential Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center:</td>
</tr>
<tr>
<td>CRID:</td>
</tr>
<tr>
<td>51 Pulmonary toxicity</td>
</tr>
<tr>
<td>yes no</td>
</tr>
<tr>
<td>52 Rejection/Poor graft function</td>
</tr>
<tr>
<td>yes no</td>
</tr>
<tr>
<td>53 VOD</td>
</tr>
<tr>
<td>yes no</td>
</tr>
<tr>
<td>54 Other</td>
</tr>
<tr>
<td>yes no</td>
</tr>
<tr>
<td>55 Specify other HSCT related cause:</td>
</tr>
<tr>
<td>56 Specify other main cause of death:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>E-mail address:</td>
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</table>