Sequence Number:	ERRO	R CORRECTI	ON FORM Recipient ID: Initials:
Today's Date:		Infusion Date:	CIBMTR Center Number:
Month Day	2 O Year	Month Day Year	CIDMITY COINCI NUMBER



2503: KGF Study Supplement

Registry Use Only Sequence Number:	
Date Received:	

Key Fields
Registry Use Only: Sequence Number:
Date Received:
CIBMTR Center Number:
CIBMTR Recipient ID:
Today's Date:
Date of HSCT for which this form is being completed:YYYY
ELSE GOTO Autologous
HSCT type (check all that apply): □ Autologous ELSE GOTO Allogeneic, unrelated
☐ Allogeneic, unrelated ELSE GOTO Allogeneic, related
☐ Allogeneic, related ELSE GOTO Syngeneic (identical twin)

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ERROR CORRECTION FORM					
Sequence Number: CIBMTR Recipient ID:	Initials:				
Today's Date: Infusion Date: CIBMTR Center Number:					
Month Day Year Month Day Year					
CIBMTR Center Number: CIBMTR Recipient ID:					
☐ Syngeneic (identical twin) ELSE GOTO Marrow					
Product Type (check all that apply): ☐ Marrow ELSE GOTO PBSC					
□ PBSC ELSE GOTO Cord blood					
□ Cord blood ELSE GOTO Other product					
☐ Other product IF Other product:= checked THEN GOTO Specify: ELSE GOTO Timepoint:					
Specify: ELSE GOTO Timepoint:					
Timepoint: O baseline pre-HSCT O 100 days post-HSCT ELSE GOTO (1) Were corrections made to the 002-Core report form according to the data reported on this for	m?				
This form should be completed for recipients selected as a case or control on the Kepivance Study where a CIBMTR 002 series Report Form was previously submitted. All questions should be answered; those questions identified as coming from the 002-Core should be answered again. The 002-Core question numbers are indicated in {brackets} for your reference to the 002-Core copy in your recipient files. 1 Were corrections made to the 002-Core report form according to the data reported on this form? O yes					
O no ELSE GOTO (2) kgf given post-HSCT					

Post-Preparative Regimen

Questions: 2-14

Has the recipient received the following hematopoietic lymphoid growth factors or cytokines after the start of the preparative regimen?

2 KGF (palifermin, Kepivance) [345.2, 408, 409]

O yes

O no

IF (2) kgf given post-HSCT:= no

THEN GOTO (5) velafermin given post-HSCT

ELSE GOTO (3) Date KGF therapy started

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ERROR CORRECTION FORM
Sequence Number: CIBMTR Recipient ID: Initials:
Today's Date: Infusion Date: CIBMTR Center Number:
Month Day Year Month Day Year
Month Day real Month Day real
CIBMTR Center Number: CIBMTR Recipient ID:
3 Date therapy started: [346]
S Date therapy started. [346]
4 Specify therapy given:[347] O prevention of acute GVHD
O planned therapy to prevent mucositis
ELSE GOTO (5) velafermin given post-HSCT
5 Velafermin [358, 359, 408, 409]
O yes
O no IF (5) velafermin given post-HSCT:= no
THEN GOTO (8) Cataracts [722]
ELSE GOTO (6) date verlafermin therapy started
6 Date therapy started:[360]
YYYY MM DD ELSE GOTO (7) indication for velafermin therapy
7 Specify therapy given:[361] O prevention of acute GVHD
O planned therapy to prevent mucositis
ELSE GOTO (8) Cataracts [722]
Specify if the recipient developed any of the following clinically significant organ impairments or disorders after the
start of the preparative regimen through the date of last contact: {715-716, 722, 727-728} 8 Cataracts [722]
O yes
O no
IF (8) Cataracts [722]:= no THEN GOTO (10) Pancreatitis [727, 728]
ELSE GOTO (9) date cataracts developed
9 Date of diagnosis:
YYYY MM DD
ELSE GOTO (10) Pancreatitis [727, 728]
10 Pancreatitis [727, 728]
O yes O no
IF (10) Pancreatitis [727, 728]:= no
THEN GOTO (12) Renal failure severe enought to warrent dialysis [715]
ELSE GOTO (11) date pancreatitis developed

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ERROR CORRECTION FORM					
Sequence Number: CIBMTR Recipient ID:	Initials:				
Today's Date: Infusion Date: CIBMTR Center Number:					
Month Day Year Month Day Year					
CIBMTR Center Number: CIBMTR Recipient ID:					
11 Date of diagnosis:					
YYYY MM DD ELSE GOTO (12) Renal failure severe enought to warrent dialysis [715]					
12 Renal failure severe enought to warrent dialysis [715] O yes O no IF (12) Renal failure severe enought to warrent dialysis [715]:= no THEN GOTO First name ELSE GOTO (13) date of renal failure					
13 Date of diagnosis:					
14 Did the recipient receive dialysis? [716]					
O yes O no					
ELSE GOTO First name					
First Name: ELSE GOTO Last name					
Last Name: ELSE GOTO Phone number:					
Phone number: ELSE GOTO Fax number:					
Fax number: ELSE GOTO E-mail address:					
E-mail address:ELSE GOTO End of Form					

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