### Post-HSCT Information

1. Has the recipient undergone cataract surgery since the date of the last report?
   1. yes
   2. no

2. Date of surgery: __________, __________, __________

3. Has the recipient received an influenza vaccine since the date of the last report?
   1. yes
   2. no

4. Has the recipient received routine post-HSCT immunizations (aside from an influenza vaccine) since the date of the last report?
   1. yes
   2. no

5. Specify the practitioner with primary responsibility for the recipient’s follow-up visits since the date of the last report:
   1. transplant practitioner at the transplant center
   2. general internist / primary care physician at the transplant center
   3. hematologist / oncologist in the community
   4. general internist / primary care physician in the community
   5. other

6. Specify practitioner: ____________________________

7. Has the recipient received a post-HSCT dental examination since the date of the last report?
   1. yes
   2. no

8. Signed: ___________________________________
   Person completing form

   Please print name: ___________________________________

   Phone: (_________) ________________ Fax: (_________) ________________

   E-mail address: ____________________________________________