ERROR CORRECTION FORM

Sequence Number: | | | | | | | | | | | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Initials:

Today's Date: Month __ __ Day __ __ Year 2 0 __ __

Infusion Date: Month __ __ Day __ __ Year 2 0 __ __

CIBMTR Center Number: __ __ __ __ __

2504: KGF Study Long-Term Follow-Up

Registry Use Only
Sequence Number:

Date Received:

Key Fields	

Sequence Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
ELSE GOTO Date Received:

Date Received: __ __ __ __ - __ __ - __ __
YYYY MM DD
ELSE GOTO CIBMTR Center Number

CIBMTR Center Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
ELSE GOTO CIBMTR Recipient ID:

CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
ELSE GOTO Today's Date:

Today's Date: __ __ __ __ - __ __ - __ __
YYYY MM DD
ELSE GOTO Date of HSCT for which this form is being completed:

Date of HSCT for which this form is being completed: __ __ __ __ - __ __ - __ __
YYYY MM DD

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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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).

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Sequence Number: | | | | | | | | | | | | | | | CIBMTR Recipient ID: | | | | | | | | | | | Initials:

Today's Date: __ __ (Month) __ __ (Day) 2 0 __ __ (Year)   Infusion Date: __ __ (Month) __ __ (Day) 2 0 __ __ (Year)   CIBMTR Center Number: __ __ __ __ __

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 Visit:

Specify: ________________________
ELSE GOTO Visit:

Visit:
- O 6 months
- O 1 year
- O 2 years
- O > 2 years,

IF Visit::= > 2 years,
THEN GOTO Specify:
ELSE GOTO (1) Cataract surgery?

Specify: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
ELSE GOTO (1) Cataract surgery?

Post-HSCT Information	Questions: 1-7

1 Has the recipient undergone cataract surgery since the date of the last report?
- O yes
- O no

IF (1) Cataract surgery?:= no
THEN GOTO (3) flu vaccine since last report?
ELSE GOTO (2) date of cataract surgery

2 Date of surgery: __ __ __ __ - __ __ - __ __ (YYYY MM DD)
ELSE GOTO (3) flu vaccine since last report?

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Infusion Date: __ __ (Month) __ __ (Day) 2 0 __ __ (Year)

CIBMTR Center Number: __ __ __ __ __

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

3 Has the recipient received an influenza vaccine since the date of the last report?
- O yes
- O no

ELSE GOTO (4) Has the recipient received routine post-HSCT immunizations (aside from an influenza vaccine) since the date of the last report?

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

ELSE GOTO (5) Specify the practitioner with primary responsibility for the recipient's follow-up visits since the date of the last report:

5 Specify the practitioner with primary responsibility for the recipient's follow-up visits since the date of the last report:
- O transplant practitioner at the transplant center
- O general internist / primary care physician at the transplant center
- O hematologist / oncologist in the community
- O general internist / primary care physician in the community
- O Other

IF (5) Specify the practitioner with primary responsibility for the recipient's follow-up visits since the date of the last report::= Other
THEN GOTO (6) Specify practitioner:
ELSE GOTO (7) Has the recipient received a post-HSCT dental examination since the date of the last report?

6 Specify practitioner: ________________________
ELSE GOTO (7) Has the recipient received a post-HSCT dental examination since the date of the last report?

7 Has the recipient received a post-HSCT dental examination since the date of the last report?
- 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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