CIBMTR Form 2504 revision 2 (page 1 of 3) Last Updated November 12, 2012.
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Mail this form to your designated campus (Milwaukee or Minneapolis. Retain the original at the transplant center.
Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
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:
☐ 6 months
☐ 1 year
☐ 2 years
☐ > 2 years.
IF Visit::= > 2 years,
THEN GOTO Specify:
ELSE GOTO (1) Cataract surgery?

Specify: ____________________________
ELSE GOTO (1) Cataract surgery?

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Post-HSCT Information

1. Has the recipient undergone cataract surgery since the date of the last report?
   ☐ yes
   ☐ 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: __________ MM __________ DD

   ELSE GOTO (3) flu vaccine since last report?

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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