

# ERROR CORRECTION FORM

Sequence Number:	CIBMTR Recipient ID:	Initials:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Today's Date:	Infusion Date:	CIBMTR Center Number:
<input type="text"/> <input type="text"/> <input type="text"/> 20 <input type="text"/>	<input type="text"/> <input type="text"/> 20 <input type="text"/>	<input type="text"/>
Month Day Year	Month Day Year	

## Form 2533 R1.0: BMT CTN 1702 Donor Testing Form

Center: \_\_\_\_\_

CRID: \_\_\_\_\_

### Key Fields

Sequence Number: \_\_\_\_\_

Date Received: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### Center Identification

CIBMTR Center Number: \_\_\_\_\_

#### Recipient Identification

CIBMTR Research ID: \_\_\_\_\_

Event date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### Donor Testing

Questions: 1 - 17

#### Donor Testing (1)

Questions: 1 - 17

#### 1 Specify donor

- Related
- Matched unrelated
- Mismatched unrelated
- Cord blood

#### 2 Specify related relationship

- Recipient's mother
- Recipient's father
- Recipient's child
- Half-sibling
- Maternal aunt
- Maternal uncle
- Maternal cousin
- Paternal aunt
- Paternal uncle
- Paternal cousin
- Grandchild
- Grandparent
- Other biological relative

#### 3 Specify other biological relative: \_\_\_\_\_

#### 4 Date of birth (donor / infant)

- Known
- Unknown

#### 5 Date of birth: (donor / infant) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### 6 Age (donor / infant)

- Known
- Unknown

#### 7 Age: (donor / infant) \_\_\_\_\_ Months (use only if less than 1 year old)

- years

#### 8 Sex (donor / infant)

- male
- female

#### 9 Date related donor sample sent to lab for typing: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### 10 Date donor HLA typing results received by transplant center: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### 11 Specify HLA allele match

- 4/8
- 5/8
- 6/8
- 7/8
- 8/8

#### 12 Was this donor selected as the final donor?

- Yes
- No

#### 13 Date donor selected: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### 14 Date donor medical clearance was received / confirmed: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.  
Retain the original form at the transplant center.

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Center: \_\_\_\_\_ CRID: \_\_\_\_\_

**15 Reason not selected**

- Donor HLA too mismatched
- Donor failed suitability assessment
- Donor not willing
- Donor unavailable for timeline
- Financial / logistical constraints
- Change in donor suitability or eligibility criteria
- Donor specific antibodies
- Donor unable or unwilling to give desired product
- DP match status not optimal
- KIR match status not optimal
- CMV match status not optimal
- ABO match status not optimal
- Other preferred donor
- Other

**16 Specify other:** \_\_\_\_\_

**17 Was documentation submitted to the CIBMTR?**

- Yes  No



First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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