CIBMTR Recipient ID Assignment Form

CIBMTR Center Number: __ __ __ __ __

Indication

1. What is the indication for CIBMTR recipient ID (CRID) assignment?
   - HCT – **Complete only questions 3 through 39**
   - Cellular therapy for regenerative medicine – **Complete only questions 19 through 39, and 41 through 43.**
   - Non-transplant therapy for MDS – **Complete only questions 19 through 38, and 40.**
   - Other indication – **Complete only questions 2, and 19 through 39.**

2. Specify other indication for CRID assignment: ______________________________________ - **Go to question 19**

Hematopoietic Cellular Transplant (HCT)

For autologous HCTs where the recipient has not given consent to allow his/her transplant data to be used for research, complete only questions 1-18, and 21 (year of birth only), then skip to signature line.

Specify the planned cell source(s) for HCT:

3. Specify HSC source:
   - Autologous – **Go to question 4**
   - Allogeneic, unrelated – **Go to question 5**
   - Allogeneic, related – **Go to question 5**

4. Has the recipient signed an IRB-approved consent form for submitting research data to the NMDP / CIBMTR?
   - Yes (patient consented)
   - No (patient declined) **Complete only questions 1-18, 21 (year of birth only), and 39.**
   - Not applicable (patient not approached) **Complete only questions 1-18, 21 (year of birth only), and 39**
Specify the planned product type(s):

5. Bone marrow
   - Yes
   - No

6. Peripheral blood stem cells
   - Yes
   - No

7. Single cord blood unit
   - Yes
   - No

8. Other product
   - Yes – Go to question 9
   - No – Go to question 10

9. Specify other product: __________________________________________________________

Copy and complete questions 3 - 9 for each donor.

10. What was the primary disease for which the HCT was performed?
    - Acute myelogenous leukemia (AML or ANLL) (10)
    - Acute lymphoblastic leukemia (ALL) (20)
    - Other acute leukemia (80)
    - Chronic myelogenous leukemia (CML) (40)
    - Myelodysplastic (MDS) / myeloproliferative (MPN) diseases (50) (Please classify all preleukemias) (If recipient has transformed to AML, indicate AML as the primary disease)
    - Other leukemia (30)
    - Hodgkin lymphoma (150)
    - Non-Hodgkin lymphoma (100)
    - Multiple myeloma / plasma cell disorder (PCD) (170)
    - Solid tumors (200)
    - Severe aplastic anemia (300) (If the recipient developed MDS or AML, indicate MDS or AML as the primary disease)
    - Inherited abnormalities of erythrocyte differentiation or function (310)
    - Disorders of the immune system (400)
11. Is this the first HCT for this recipient: (Do not include donor cellular infusions.)
   ☐ Yes – Go to question 19
   ☐ No – Go to question 12

12. Date of the last HCT (just before current HCT): ___ ___ ___ ___ — ___ ___ — ___ ___

13. Specify HSC source for the last HCT:
   ☐ Autologous
   ☐ Allogeneic, unrelated
   ☐ Allogeneic, related

Specify product type(s) for the last HCT:

14. Bone marrow
   ☐ Yes
   ☐ No

15. Peripheral blood stem cells (PBSC)
   ☐ Yes
   ☐ No

16. Single cord blood unit
   ☐ Yes
   ☐ No

17. Other product
   ☐ Yes – Go to question 18
   ☐ No – Go to question 19

18. Specify other product: ________________________________

Copy and complete questions 13 - 18 for each donor.
Recipient Data

19. First name: ____________________________

20. Last name: ____________________________

21. Date of birth: __ __ __ __ — __ __ — __ __
    YYYY MM DD

Location of birth:

22. Country: ______________________________________

23. City: ______________________________________

24. State: ______________________________________

25. Sex:
   □ Male
   □ Female

26. Is the recipient’s social security number provided?
   □ Yes – Go to question 27
   □ No – Go to question 28
   □ Not applicable (e.g. not a U.S. citizen) – Go to question 28

   27. Recipient Social Security number: ___ ___ ___ —___ ___ —___ ___ ___ ___

28. Does the recipient have a Recipient NMDP ID?
   □ Yes – Go to question 29
   □ No – Go to question 30

   29. Recipient NMDP ID: ___ ___ ___ — ___ ___ ___ — ___

30. Does the recipient have a Recipient EBMT ID?
   □ Yes – Go to question 31
   □ No – Go to question 32
31. Recipient EBMT ID: ___ ___ ___ — ___ ___ ___ ___— ___

32. Does the recipient have an EBMT CIC?
   ☐ Yes – Go to question 33
   ☐ No – Go to question 34

33. EBMT CIC: ___ ___ ___ ___ ___

34. Does the recipient have an IUBMID?
   ☐ Yes – Go to question 35
   ☐ No – Go to question 36

35. Recipient IUBMID (former IBMTR #): ___ ___ ___ ___ ___ ___

36. Does the recipient have a Team ID?
   ☐ Yes – Go to question 37
   ☐ No – Go to question 38

37. Team ID (former CIBMTR #): ___ ___ ___ ___

38. Recipient’s mother’s maiden name: (optional for non-U.S. centers)
   ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - If indication is for non-transplant therapy for MDS, go to question 40. Otherwise go to question 39.

39. Planned infusion date: ___ ___ ___ ___ — ___ ___ — ___ ___ - If indication is cellular therapy for regenerative medicine, go to question 41.
   All other indications, go to signature line.

40. Enrollment date: ___ ___ ___ ___ - ___ ___ - ___ ___ - Go to signature line
   YYYY MM DD

Cellular Therapy for Regenerative Medicine

41. Indication for cellular therapy:
   ☐ Autoimmune disease (600) – Go to question 43
   ☐ Cardio and peripheral vascular disease (700) – Go to question 43
   ☐ Musculoskeletal disease (720) – Go to question 43
   ☐ Neurologic disease (730) – Go to question 43
   ☐ Other disease (900) – Go to question 42
42. Specify other indication for cellular therapy: _________________________________________________

43. Is this the first application of cellular therapy for this indication?
   ☐ Yes
   ☐ No

First Name:________________________________________________________________________________

Last Name:_______________________________________________________________________________

E-mail address: __________________________________________________________________________

Date: ___ ___ ___ ___ — ___ ___ — ___ ___

YYYY      MM      DD