### Key Fields

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<th>Value</th>
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<tr>
<td>Sequence Number:</td>
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<tr>
<td>Date Received:</td>
<td></td>
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<tr>
<td>CIBMTR Center Number:</td>
<td></td>
</tr>
<tr>
<td>CIBMTR Research ID:</td>
<td></td>
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</tbody>
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### Indication

**Questions: 1 - 1**

1. What is the indication for CIBMTR Research ID (CRID) assignment?
   - [ ] HCT
   - [ ] Cellular therapy (non-HCT)
   - [ ] Marrow toxic injury
   - [ ] Non-cellular therapy (e.g. chemotherapy, immunotherapy, etc.)

### Hematopoietic Cellular Transplant (HCT)

**Questions: 2 - 5**

2. Autologous
   - [ ] yes
   - [ ] no

3. Allogeneic, unrelated
   - [ ] yes
   - [ ] no

4. Allogeneic, related
   - [ ] yes
   - [ ] no

5. Planned HCT date: __ __ __ __ - __ __- __ __

### Cellular Therapy

**Questions: 6 - 8**

6. Planned infusion date: __ __ __ __ - __ __- __ __

7. Indication for cellular therapy
   - [ ] Autoimmune disease (600)
   - [ ] Cardio and peripheral vascular disease (700)
   - [ ] Musculoskeletal disease (720)
   - [ ] Neurologic disease (730)
   - [ ] Other disease (900)

8. Specify other indication for cellular therapy:

### Marrow Toxic Injury

**Questions: 9 - 9**

9. Event date: __ __ __ __ - __ __- __ __

### Non-Cellular Therapy

**Questions: 10 - 12**

10. Specify the disease for which non-cellular therapy was given
    - [ ] MDS
    - [ ] Other disease

11. Specify other disease:

12. Enrollment date: __ __ __ __ - __ __- __ __
    (date of consent)

First Name: __________________________ Last Name: __________________________
E-mail address: __________________________
Date: __ __ __ __ - __ __- __ __

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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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