Form 2900 R2.0: Recipient Death Data

Key Fields

Sequence Number: __________________________

Date Received: __ __ __ __ - __ __ __

CIBMTR Center Number: __________________________

CIBMTR Recipient ID: __________________________

Today's Date: __ __ __ __ - __ __ __

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

HSCT Type (check all that apply):

☐ Autologous
☐ Allogeneic, unrelated
☐ Allogeneic, related
☐ Syngeneic (identical twin)

Product Type (check all that apply):

☐ Marrow
☐ PBSC
☐ Cord blood
☐ multiple cord blood units infused
☐ Other product

Specify: __________________________

Death Data Questions: 1 - 7

1 Date of death: __ __ __ __ - __ __ __ ☐ date estimated

2 Was cause of death confirmed by autopsy?

☐ Yes ☐ Autopsy pending ☐ No ☐ Unknown

3 Is an autopsy report attached?

☐ yes ☐ no

4 Primary cause of death: __________________________

5 Specify: __________________________

Contributing Cause of Death (1) Questions: 6 - 7

6 Contributing cause of death: __________________________

7 Specify: __________________________

First Name: __________________________ Last Name: __________________________