

Core Insert

FOR REGISTRY USE ONLY:
 I.D. - -
 Date received:
 Log: _____ PC: _____

TEAM: IUBMID:
(Institutional Unique Blood or Marrow Transplant Identification Number)


1. Date of HSCT for which this form is being completed:

 Month Day Year

Registry (circle one): **IBMTR** ABMTR
 2. Date of report:
 Month Day Year

(Use same date on Graft Insert & Disease Insert for this transplant.)

Series 2002 Reporting Forms



Statistical Center
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 Milwaukee, WI 53226
 Telephone: 414-456-8325 Fax: 414-456-6530
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3. Day 100 posttransplant:
 Month Day Year

4. Date of last actual contact (LCD) with patient to determine medical status for this report:

 Month Day Year

(See Qs.vii-xi on pg 40 for help determining date of last contact.)

(if patient died prior to Day 100 with no further infusions, enter date of death and check here .)

Demographics*

*** If this is a report of a second (or subsequent) transplant check here , complete Disease Insert and go to Q.13**

5. Institutional protocol number (if applicable):

6. Sex: 1 Male 2 Female

7. Date of birth:
 Month Day Year

8. Ethnicity: 1 Hispanic or Latino 2 Non Hispanic or non-Latino 8 Unknown

9. Race: *(If patient's parents are from two separate groups of the following, check both)*

- | | | |
|---|---|---|
| <p>Caucasian/White</p> <p>10 <input type="checkbox"/> White, NOS</p> <p>11 <input type="checkbox"/> Eastern European</p> <p>12 <input type="checkbox"/> European, NOS</p> <p>13 <input type="checkbox"/> Mediterranean</p> <p>82 <input type="checkbox"/> North Coast of Africa</p> <p>83 <input type="checkbox"/> Middle Eastern</p> <p>14 <input type="checkbox"/> White North American</p> <p>17 <input type="checkbox"/> Northern European</p> <p>18 <input type="checkbox"/> Western European</p> <p>81 <input type="checkbox"/> White Caribbean</p> <p>15 <input type="checkbox"/> White South or Central American</p> <p>Black</p> <p>20 <input type="checkbox"/> Black, NOS</p> | <p>22 <input type="checkbox"/> African Black (both parents born in Africa)</p> <p>21 <input type="checkbox"/> African American</p> <p>23 <input type="checkbox"/> Caribbean Black</p> <p>24 <input type="checkbox"/> South or Central American Black</p> <p>Asian/Pacific Islander</p> <p>30 <input type="checkbox"/> Asian, NOS</p> <p>31 <input type="checkbox"/> Asian Indian/South Asian</p> <p>36 <input type="checkbox"/> Chinese</p> <p>32 <input type="checkbox"/> Filipino</p> <p>34 <input type="checkbox"/> Japanese</p> <p>35 <input type="checkbox"/> Korean</p> <p>38 <input type="checkbox"/> Vietnamese</p> <p>37 <input type="checkbox"/> Other Southeast Asian</p> | <p>60 <input type="checkbox"/> Native Pacific Islander, NOS</p> <p>61 <input type="checkbox"/> Guamanian</p> <p>62 <input type="checkbox"/> Hawaiian</p> <p>63 <input type="checkbox"/> Samoan</p> <p>Native American</p> <p>50 <input type="checkbox"/> Native American, NOS</p> <p>51 <input type="checkbox"/> Native Alaskan/Eskimo/Aleut</p> <p>52 <input type="checkbox"/> American Indian</p> <p>53 <input type="checkbox"/> North American Indian</p> <p>54 <input type="checkbox"/> South or Central American Indian</p> <p>55 <input type="checkbox"/> Caribbean Indian</p> <p>Other</p> <p>88 <input type="checkbox"/> Unknown</p> <p>90 <input type="checkbox"/> Other, 10. specify: _____</p> |
|---|---|---|

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TEAM:

IUBMID:

Disease

11. What was the primary disease for which transplant was performed? (Appropriate Disease Insert must be submitted with this form. Subsequent transplants: complete same disease insert as for transplant #1.)

10 Acute myelogenous leukemia (AML or ANLL)

- 70 Transformed from MDS
~also tick AML subtype~
- 38 M0, stem cell
- 11 M1, myeloblastic
- 12 M2, myelocytic
- 13 M3, promyelocytic (APML, APL)
- 14 M4, myelomonocytic
- 15 M5, monocytic
- 16 M6, erythroblastic
- 17 M7, megakaryoblastic
- 19 Other AML, specify: _____
- 10 AML or ANLL, NOS

Complete AML Insert and continue with Q.12 on Pg 6

40 Chronic myelogenous leukemia (CML)

- 41 Ph¹⁺; BCR/ABL+
- 42 Ph¹⁺; BCR/ABL-
- 43 Ph¹⁺; BCR/ABL unknown
- 44 Ph¹⁻; BCR/ABL+
- 45 Ph¹⁻; BCR/ABL-
- 46 Ph¹⁻; BCR/ABL unknown
- 47 Ph¹ unknown; BCR/ABL+
- 48 Ph¹ unknown; BCR/ABL-
- 40 Ph¹ unknown; BCR/ABL unknown

Complete CML Insert and continue with Q.12 on Pg 6

20 Acute lymphoblastic leukemia (ALL)

- 26 B-lineage, NOS
- 22 T-cell
- 23 Null cell (early Pre-B)
- 24 cALLa (includes Pre-B)
- 21 Mature B-cell (L3)
- 126 Large granular lymphocytic leukemia
- 27 Aggressive NK-cell leukemia
- 134 Adult T-cell lymphoma/leukemia
(HTLV1 associated)
- 29 Other ALL, specify: _____
- 20 ALL, NOS

Complete ALL Insert and continue with Q.12 on Pg 6

50 Myelodysplastic/myeloproliferative disorders (MDS)

(Please identify all preleukemias)

(If patient has transformed to AML, also complete AML Insert and indicate AML as the primary disease)

- 51 Refractory anemia (RA)
- 52 Acquired idiopathic sideroblastic anemia (RARS)
- 52 Refractory anemia with excess blasts (RAEB)
- 53 Refractory anemia with excess blasts in transformation (RAEB-t)
- 54 Chronic myelomonocytic leukemia (CMML)
- 67 Other MDS, specify: _____
- 50 MDS, NOS
- 60 MPS, NOS
- 57 Polycythemia vera
- 58 Essential or primary thrombocythemia
- 59 Myelofibrosis with myeloid metaplasia
- 63 Acute myelofibrosis or myelosclerosis
- 69 Other MFS/MPS, specify: _____

Complete MDS Insert and continue with Q.12 on Pg 6

80 Other acute leukemia

- 31 Acute undifferentiated leukemia
- 32 Biphenotypic, bilineage or hybrid leukemia
- 33 Acute myeloid leukemia
- 89 Other acute leukemia, specify: _____
- 80 Acute leukemia, NOS

Complete AML Insert and continue with Q.12 on Pg 6

36 Juvenile CML (JMML or JCML) (no evidence of Philadelphia chromosome or BCR/ABL)

Complete JMM Insert and continue with Q.12 on Pg 6

30 Other leukemia

- 55 Chronic lymphocytic leukemia (CLL), NOS
- 71 CLL, B-cell/small cell lymphocytic lymphoma
- 72 CLL, T-cell
- 35 Hairy cell leukemia
- 37 Prolymphocytic leukemia (PLL)
- 73 PLL, B-cell
- 74 PLL, T-cell

Complete CLL Insert and continue with Q.12 on Pg 6

39 Other leukemia, specify: _____

30 Other leukemia, NOS

Complete AML Insert and continue with Q.12 on Pg 6

170 Multiple myeloma/Plasma cell disorder (PCD)

- 171 Multiple myeloma, NOS
- 172 Plasma cell leukemia
- 175 Solitary plasmacytoma
- 179 Other PCD, specify: _____
- 170 Plasma cell disorders, NOS

Complete MYE Insert and continue with Q.12 on Pg 6

173 Waldenstrom macroglobulinemia (IgM)

Complete MAC Insert and continue with Q.12 on Pg 6

174 Amyloidosis

Complete AMY Insert and continue with Q.12 on Pg 6

TEAM:

IUBMID:

100 Non-Hodgkin lymphoma

- 109 Precursor B-lymphoblastic lymphoma/leukemia (precursor B-cell acute lymphoblastic leukemia)
- 121 Small lymphoplasmacytic lymphoma
- 124 Splenic marginal zone B-cell lymphoma
- 122 Extranodal marginal zone B-cell lymphoma of Mucosal Associated Lymphoid Tissue type
- 123 Nodal marginal zone B-cell lymphoma (+/- monocytoid B-cells)
- 102 Follicular, predominantly small cleaved cell (Grade I follicle center lymphoma)
- 103 Follicular, mixed, small cleaved and large cell (Grade II follicle center lymphoma)
- 104 Follicular, predominantly large cell (Grade III follicle center lymphoma)
- 164 Follicular (unknown grade)
- 115 Mantle cell
- 107 Diffuse large B-cell lymphoma, including Primary mediastinal (thymic) large B-cell lymphoma (large B-cell lymphoma subtype)
- 111 Burkitt lymphoma/Burkitt cell leukemia
- 135 High-grade B-cell lymphoma, Burkitt-like (provisional entity)
- 129 Other B-cell lymphoma, specify: _____

- 127 Precursor T-lymphoblastic lymphoma/leukemia (precursor T-cell acute lymphoblastic leukemia)
- 137 Extranodal NK/T-cell lymphoma, nasal type
- 133 Enteropathy-type T-cell lymphoma
- 145 Hepatosplenic gamma-delta T-cell lymphoma
- 146 Subcutaneous panniculitis-like T-cell lymphoma
- 113 Mycosis fungoides/Szary syndrome
- 147 Anaplastic large-cell lymphoma, T/null cell, primary cutaneous type
- 130 Peripheral T-cell lymphoma, NOS
- 131 Angioimmunoblastic T-cell lymphoma
- 148 Anaplastic large-cell lymphoma, T/null cell, primary systemic type
- 139 Other T-cell/NK-cell lymphoma, specify: _____

- 100 Non-Hodgkin lymphoma, NOS
- 118 Primary CNS lymphoma

Complete LYM Insert and continue with Q.12 on Pg 6

150 Hodgkin lymphoma

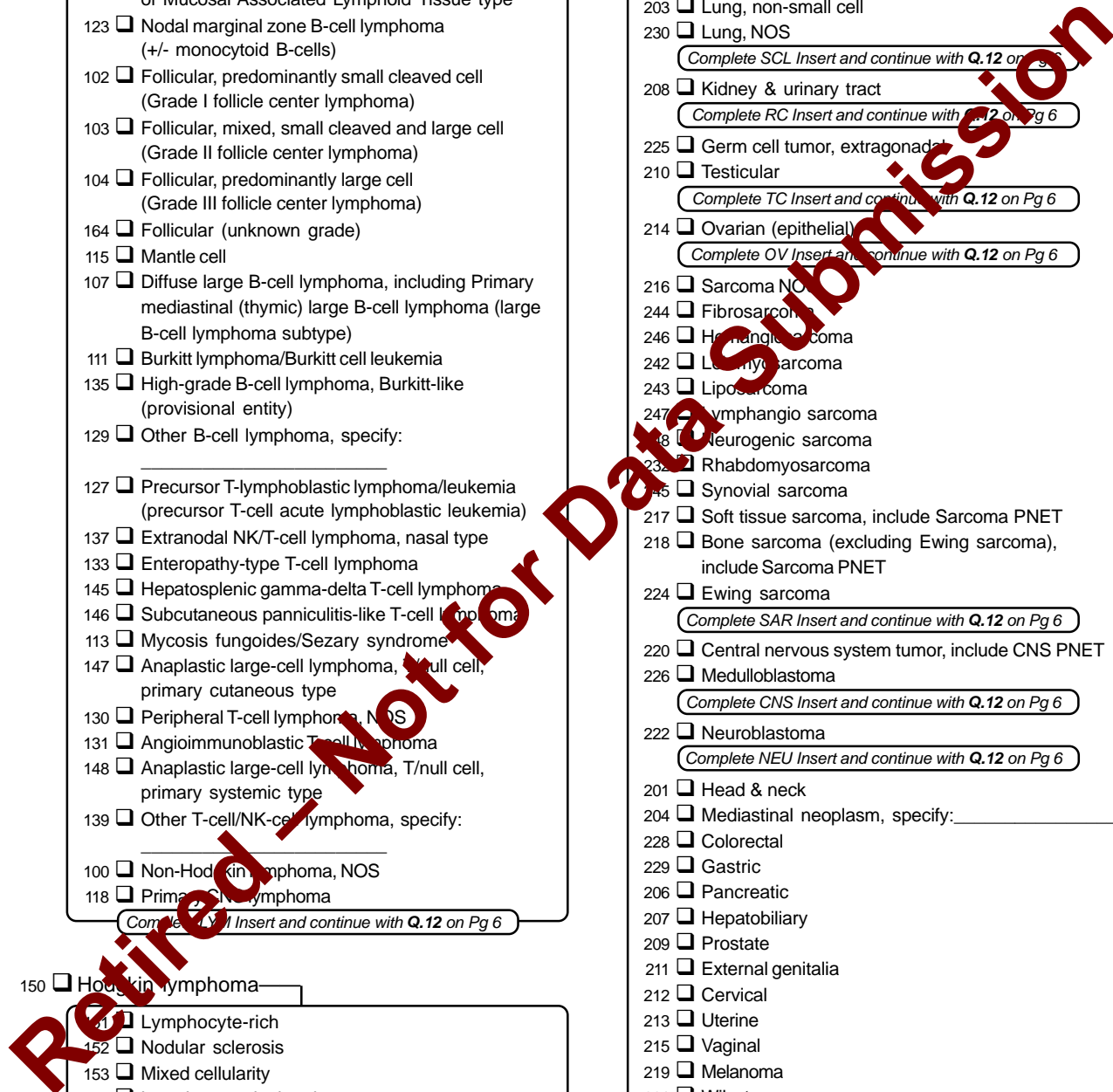
- 151 Lymphocyte-rich
- 152 Nodular sclerosis
- 153 Mixed cellularity
- 154 Lymphocyte depleted
- 159 Other Hodgkin lymphoma, specify: _____
- 150 Hodgkin lymphoma, NOS

Complete LYM Insert and continue with Q.12 on Pg 6

200 Solid tumor

- 250 Breast cancer, NOS
- 251 Breast cancer inflammatory
- 252 Breast cancer non-inflammatory
Complete BC Insert and continue with Q.12 on Pg 6
- 202 Lung, small cell
- 203 Lung, non-small cell
- 230 Lung, NOS
Complete SCL Insert and continue with Q.12 on Pg 6
- 208 Kidney & urinary tract
Complete RC Insert and continue with Q.12 on Pg 6
- 225 Germ cell tumor, extragonadal
- 210 Testicular
Complete TC Insert and continue with Q.12 on Pg 6
- 214 Ovarian (epithelial)
Complete OV Insert and continue with Q.12 on Pg 6
- 216 Sarcoma NOS
- 244 Fibrosarcoma
- 246 Hemangioma
- 242 Leiomyosarcoma
- 243 Liposarcoma
- 247 Lymphangio sarcoma
- 248 Neurogenic sarcoma
- 232 Rhabdomyosarcoma
- 245 Synovial sarcoma
- 217 Soft tissue sarcoma, include Sarcoma PNET
- 218 Bone sarcoma (excluding Ewing sarcoma), include Sarcoma PNET
- 224 Ewing sarcoma
Complete SAR Insert and continue with Q.12 on Pg 6
- 220 Central nervous system tumor, include CNS PNET
- 226 Medulloblastoma
Complete CNS Insert and continue with Q.12 on Pg 6
- 222 Neuroblastoma
Complete NEU Insert and continue with Q.12 on Pg 6
- 201 Head & neck
- 204 Mediastinal neoplasm, specify: _____
- 228 Colorectal
- 229 Gastric
- 206 Pancreatic
- 207 Hepatobiliary
- 209 Prostate
- 211 External genitalia
- 212 Cervical
- 213 Uterine
- 215 Vaginal
- 219 Melanoma
- 221 Wilm tumor
- 223 Retinoblastoma
- 231 Thymoma
- 269 Other solid tumor, specify: _____
- 200 Solid tumor, NOS

Continue with Q.12 on Pg 6



TEAM:

IUBMID:

300 Severe aplastic anemia

- 301 Idiopathic
- 302 Secondary to hepatitis
- 303 Secondary to toxin/other drug
- 304 Amegakaryocytosis (not congenital)
- 306 Acquired Pure Red Cell Aplasia
- 309 Other acquired cytopenic syndrome,
specify: _____
- 56 Paroxysmal nocturnal hemoglobinuria (PNH)

Complete APL Insert and continue with Q.12 on Pg 6

310 Inherited abnormalities of erythrocyte differentiation or function (If patient has developed leukemia, also complete Insert for appropriate leukemia diagnosis)

- 305 Schwachmann-Diamond
- 312 Diamond-Blackfan anemia (pure red cell aplasia)
Complete APL Insert and continue with Q.12 on Pg 6
- 311 Fanconi anemia
Complete FAN Insert and continue with Q.12 on Pg 6
- 355 Sickle Thalassemia
- 356 Sickle cell disease
Complete SCA Insert and continue with Q.12 on Pg 6

- 350 Thalassemia, NOS
- 359 Other hemoglobinopathy,
specify: _____

310 Inherited abnormalities of erythrocyte differentiation or function, NOS
Continue with Q.12 on Pg 6

- 319 Other constitutional anemia,
specify: _____
Complete APL Insert and continue with Q.12 on Pg 6

400 Disorders of the immune system

- 401 ADA deficiency
severe combined immunodeficiency (SCID)
- 402 Absence of T and B cells SCID
- 403 Absence of T, normal B cell SCID
- 404 Omenn syndrome
- 405 Reticular dysgenesis
- 406 Bare lymphocyte syndrome
- 410 SCID, NOS
- 419 SCID other, specify: _____
- 451 Ataxia telangiectasia
- 452 HIV infection
- 454 DiGeorge anomaly
- 455 Chronic granulomatous disease
- 457 Common variable immunodeficiency
- 458 X-linked lymphoproliferative syndrome
- 459 Leukocyte adhesion deficiencies, incl. GP180,
CD-18, LFA and VBC adhesion deficiencies
- 460 Kostmann granulocytosis
(congenital neutropenia)
- 461 Nodular actin deficiency
- 462 Cartilage-hair hypoplasia
- 464 CD40 ligand deficiency
- 470 Combined immunodeficiency disease (CID), NOS
- 471 CID other, specify: _____
- 479 Other immunodeficiencies, specify: _____
- 400 Immune Deficiencies (ID), NOS
Complete ID Insert and continue with Q.12 on Pg 6
- 456 Chediak-Higashi syndrome
Complete CHS Insert and continue with Q.12 on Pg 6
- 453 Wiskott Aldrich syndrome
Complete WAS Insert and continue with Q.12 on Pg 6

500 Inherited abnormalities of platelets

- 501 Amegakaryocytosis/congenital thrombocytopenia
- 502 Glanzmann thrombasthenia
- 509 Other inherited abnormalities of platelets,
specify: _____
- 500 Inherited abnormalities of platelets, NOS
Continue with Q.12 on Pg 6

900 Other (Fax Pathology Report to 414-456-6530 before using this designation or attach Pathology Report from diagnosis and check here)

Specify: _____
Continue with Q.12 on Pg 6

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TEAM:

IUBMID:

520 Inherited disorders of metabolism

521 Osteopetrosis (malignant infantile osteopetrosis)
Complete OST Insert and continue with Q.12 on Pg 6

Leukodystrophies

542 Metachromatic leukodystrophy (MLD)
543 Adrenoleukodystrophy (ALD)
544 Krabbe disease (globoid leukodystrophy)
Complete LDS Insert and continue with Q.12 on Pg 6

522 Lesch-Nyhan (HGPRT deficiency)
523 Neuronal ceroid lipofuscinosis (Batten disease)

Mucopolysaccharidoses

531 Hurler syndrome (IH)
532 Scheie syndrome (IS)
533 Hunter syndrome (II)
534 Sanfilippo (III)
535 Morquio (IV)
536 Maroteaux-Lamy (VI)
537 β -glucuronidase deficiency (VII)
538 Mucopolysaccharidosis (V)
539 Other mucopolysaccharidosis, specify: _____

530 Mucopolysaccharidosis, NOS

Mucopolipidoses

541 Gaucher disease
545 Neimann-Pick disease
546 I-cell disease
547 Wolman disease
548 Glucose storage disease
549 Lysosomal storage disease
559 Other mucopolipidoses, specify: _____

540 Mucopolipidoses, NOS

Polysaccharide hydrolase abnormalities

561 Aspartyl glucosaminuria
562 Fucosidosis
563 Mannosidosis
569 Other polysaccharide hydrolase abnorm., specify: _____

560 Polysaccharide hydrolase abnorm., NOS
529 Other inherited metabolic disorders, specify: _____

520 Inherited disorders of metabolisms, NOS
Complete MUC Insert and continue with Q.12 on Pg 6

570 Histiocytic disorders

571 Familial erythrophagocytic lymphohistiocytosis (FELH)
572 Langerhans cell histiocytosis (Histiocytosis-X)
Complete LCH Insert and continue with Q.12 on Pg 6

573 Hemophagocytosis (reactive or viral associated)
574 Malignant histiocytosis
579 Other histiocytic disorder, specify: _____

570 Histiocytic disorder, NOS
Continue with Q.12 on Pg 6

600 Autoimmune diseases

Connective Tissue Disease

607 Systemic Sclerosis (Scleroderma)
Complete SSC Insert and continue with Q.12 on Pg 6

605 Systemic lupus erythematosus (SLE)
Complete SLE Insert and continue with Q.12 on Pg 6

608 Sjögren syndrome
606 Polymyositis-dermatomyositis
614 Antiphospholipid syndrome
634 Other connective tissue disease, specify: _____

Vasculitis

610 Wegener granulomatosis
609 Polyarteritis nodosa
631 Classical
632 Microscopic
635 Churg-Straus
636 Giant cell arteritis
637 Takayasu
638 Behçet syndrome
639 Overlap necrotizing arteritis
611 Other vasculitis, specify: _____

Arthritis

603 Rheumatoid arthritis
Complete RA Insert and continue with Q.12 on Pg 6

604 Psoriatic arthritis/psoriasis
640 JIA: Systemic (Stills Disease)
641 JIA: Oligoarticular
642 JIA: Polyarticular
643 JIA: Other, specify: _____
Complete JRA Insert and continue with Q.12 on Pg 6

633 Other arthritis, specify: _____
Complete JRA Insert and continue with Q.12 on Pg 6

Multiple Sclerosis

602 Multiple sclerosis
Complete MS Insert and continue with Q.12 on Pg 6

Other Neurological Autoimmune Disease

601 Myasthenia gravis
644 Other autoimmune neurological disorder, specify: _____

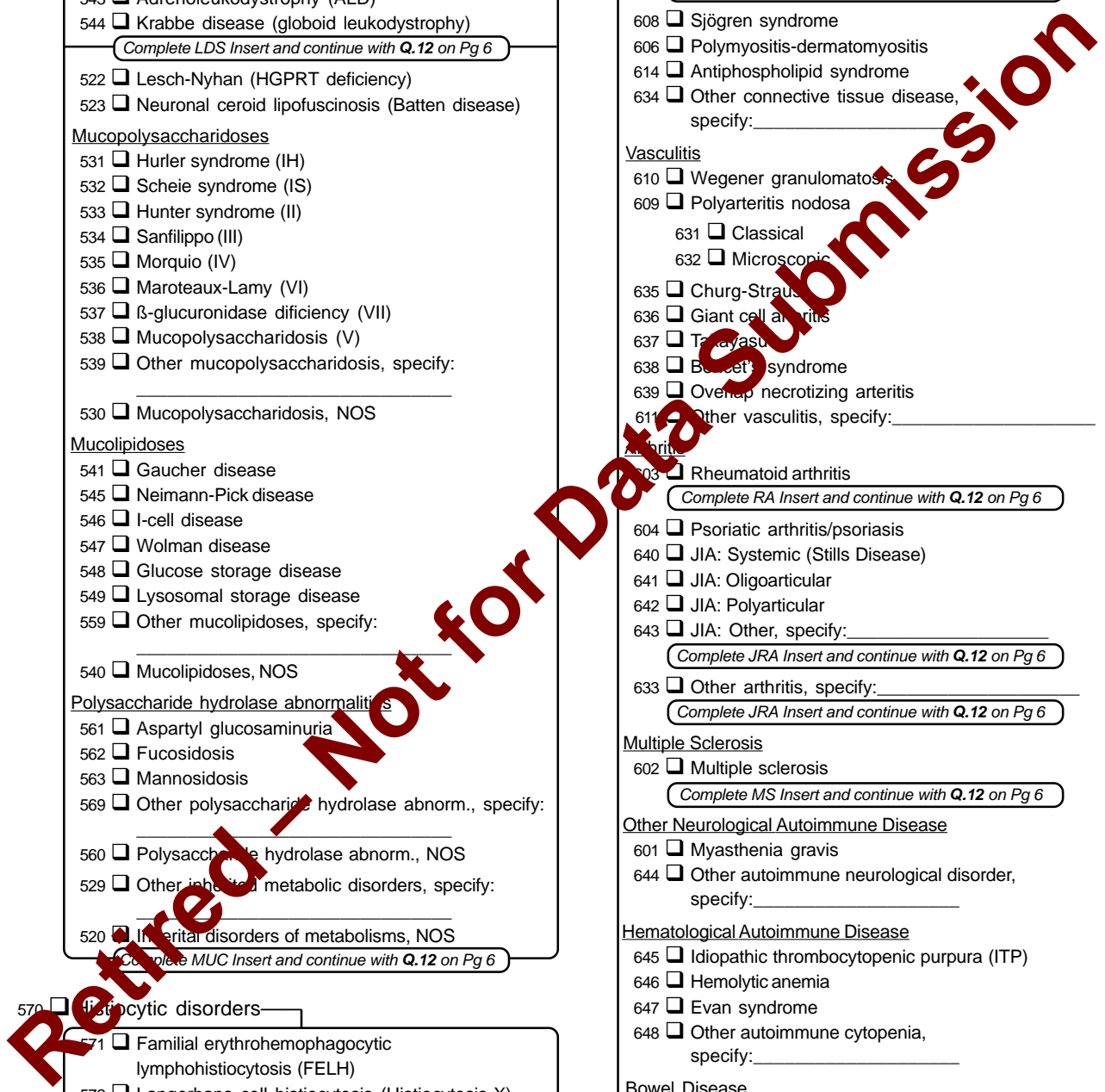
Hematological Autoimmune Disease

645 Idiopathic thrombocytopenic purpura (ITP)
646 Hemolytic anemia
647 Evan syndrome
648 Other autoimmune cytopenia, specify: _____

Bowel Disease

649 Crohn's disease
650 Ulcerative colitis
651 Other autoimmune bowel disorder, specify: _____

629 Other autoimmune disease, specify: _____
Continue with Q.12 on Pg 6



TEAM:

IUBMID:

Clinical Status of Patient Prior to Conditioning

12. **Allografts only:** Patient's blood type:

- 1 A Rh positive
- 2 B Rh positive
- 3 AB Rh positive
- 4 O Rh positive
- 5 A Rh negative
- 6 B Rh negative
- 7 AB Rh negative
- 8 O Rh negative
- 9 A Rh unknown
- 10 B Rh unknown
- 11 AB Rh unknown
- 12 O Rh unknown
- 88 Unknown

Abbreviations Used in This Report Form

BM = Bone Marrow
DCI = Donor Cellular Infusion
EBV = Epstein-Barr Virus
HSCT = Hematopoietic Stem Cell Transplant
IT = Intrathecal
LCD = Last Contact Date
NOS = Not Otherwise Specified
PB = Peripheral Blood
PCR = Polymerase Chain Reaction
PTLD = Posttransplant Lymphoproliferative Disorder
VATS = Video Assisted Thoroscopic Surgery
VOD = Veno-occlusive Disease

13. Functional status of patient prior to conditioning:

*If patient is 16 years of age or older, complete the Karnofsky Scale.
 If patient is younger than 16 years of age, complete the Lansky Scale.
 Rate activity of patient immediately prior to initiation of conditioning.*

Karnofsky Scale (age ≥16 yrs)	Lansky Scale (age <16 yrs)
<p style="text-align: center;"><i>Select the phrase in the Karnofsky Scale which best describes the activity status of the patient.</i></p> <p>Able to carry on normal activity; no special care is needed.</p> <p>100 <input type="checkbox"/> Normal; no complaints; no evidence of disease 90 <input type="checkbox"/> Able to carry on normal activity 80 <input type="checkbox"/> Normal activity with effort</p> <p>Unable to work; able to live at home; care for most personal needs; a varying amount of assistance is needed.</p> <p>70 <input type="checkbox"/> Cares for self; unable to carry on normal activity or to do active work 60 <input type="checkbox"/> Requires occasional assistance but is able to care for most needs 50 <input type="checkbox"/> Requires considerable assistance and frequent medical care</p> <p>Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.</p> <p>40 <input type="checkbox"/> Disabled; requires special care and assistance 30 <input type="checkbox"/> Severely disabled; hospitalization indicated, although death not imminent 20 <input type="checkbox"/> Very sick; hospitalization necessary 10 <input type="checkbox"/> Moribund; fatal process progressing rapidly</p>	<p style="text-align: center;"><i>Select the phrase in the Lansky Play-Performance Scale which best describes the activity status of the patient</i></p> <p>Normal range.</p> <p>100 <input type="checkbox"/> Fully active 90 <input type="checkbox"/> Minor restriction in physically strenuous play 80 <input type="checkbox"/> Restricted in strenuous play, tires more easily, otherwise active</p> <p>Mild to moderate restriction.</p> <p>70 <input type="checkbox"/> Both greater restrictions of, and less time spent in, active play 60 <input type="checkbox"/> Ambulatory up to 50% of time, limited active play with assistance/supervision 50 <input type="checkbox"/> Considerable assistance required for any active play; fully able to engage in quiet play</p> <p>Moderate to severe restriction.</p> <p>40 <input type="checkbox"/> Able to initiate quiet activities 30 <input type="checkbox"/> Needs considerable assistance for quiet activity 20 <input type="checkbox"/> Limited to very passive activity initiated by others (i.e., TV) 10 <input type="checkbox"/> Completely disabled, not even passive play</p>

Strd Fig A-54

If this is a report of a second (or subsequent) transplant, skip Q.14 and continue with Q.59

TEAM:

IUBMID:

14. Was there clinically significant coexisting disease or organ impairment anytime prior to conditioning?

- 1 Yes
- 0 No
- 8 Unknown

Specify diagnoses (*check all that apply*):

	Yes	No	Unknown	
15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant <i>hemorrhage</i> (e.g. CNS or GI) 16. Specify site(s): _____
17.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of <i>other malignancy</i> 18. Specify: _____
<i>Autoimmune disease</i>				
19.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis (MS)
20.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polyarteritis nodosa
21.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
22.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis (RA)
23.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus (SLE)
24.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other autoimmune disease 25. Specify: _____
<i>Cardiovascular</i>				
26.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary artery disease
27.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
28.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other cardiac disease 29. Specify: _____
<i>Chromosomal</i>				
30.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Down syndrome
31.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fanconi anemia
32.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other chromosomal disorders 33. Specify: _____
<i>CNS/Psychiatric</i>				
34.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
35.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder
36.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other 37. Specify: _____
<i>Endocrine</i>				
38.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus
39.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
40.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other endocrine disease 41. Specify: _____
42.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Gastrointestinal</i> disease 43. Specify: _____
44.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Genitourinary</i> disease 45. Specify: _____
46.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Hematologic</i> disease 47. Specify: _____
<i>Liver disease</i>				
48.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug toxicity
49.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A virus
50.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B virus
51.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C virus
52.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other liver disease 53. Specify: _____
<i>Pulmonary</i>				
54.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
55.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other pulmonary disease 56. Specify: _____
57.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Other</i> 58. Specify: _____

Retired - Not for Data Submission

TEAM: [][][][]

IUBMID: [][][][][][][]

Organ Function Values Just Prior to Conditioning (provide last lab values recorded prior to the first dose of the conditioning regimen) See Q.107 first

		Specify Units		Date tested:			Not
				Month	Day	Year	Tested
59.	AST (SGOT):	[][][] . [][]	1 <input type="checkbox"/> U/L 2 <input type="checkbox"/> μ kat/L	60.	[][][]	[][][]	<input type="checkbox"/>
61.		[][][] . [][]	Upper limit of normal				
62.	Total serum bilirubin:	[][][] . [][]	1 <input type="checkbox"/> mg/dL 2 <input type="checkbox"/> μ mol/L	63.	[][][]	[][][]	<input type="checkbox"/>
64.		[][][] . [][]	Upper limit of normal				
65.	LDH:	[][][][] . [][]	1 <input type="checkbox"/> U/L 2 <input type="checkbox"/> μ kat/L	66.	[][][]	[][][]	<input type="checkbox"/>
67.		[][][][] . [][]	Upper limit of normal				
68.	Serum creatinine:	[][][] . [][]	1 <input type="checkbox"/> mg/dL 2 <input type="checkbox"/> μ mol/L 3 <input type="checkbox"/> mmol/L	69.	[][][]	[][][]	<input type="checkbox"/>

Hematologic Findings Just Prior to Conditioning

		Specify Units		Date tested:			Not
				Month	Day	Year	Tested
CBC results:				70.	[][][]	[][][]	
71.	WBC:	[][][][] . [][]	1 <input type="checkbox"/> $\times 10^9/L$ ($\times 10^9/mm^3$) 2 <input type="checkbox"/> $\times 10^6/L$				<input type="checkbox"/>
72.	Neutrophils:	[][] %					<input type="checkbox"/>
73.	Lymphocytes:	[][] %					<input type="checkbox"/>
74.	Hemoglobin:	[][][] . [][]	1 <input type="checkbox"/> g/dl 2 <input type="checkbox"/> g/L 3 <input type="checkbox"/> mmol/L				<input type="checkbox"/>
						<input type="checkbox"/> Transfused	<input type="checkbox"/>
						RBC <30 days from Q.70	
75.	Hematocrit:	[][] %				<input type="checkbox"/> Transfused	<input type="checkbox"/>
						RBC <30 days from Q.70	
76.	Platelets:	[][][][]	1 <input type="checkbox"/> $\times 10^9/L$ ($\times 10^3/mm^3$) 2 <input type="checkbox"/> $\times 10^6/L$			<input type="checkbox"/> Transfused	<input type="checkbox"/>
						platelets <7 days from Q.70	
77.	Does patient smoke cigarettes or have a history of smoking cigarettes?						
1	<input type="checkbox"/> Yes						
0	<input type="checkbox"/> No						
8	<input type="checkbox"/> Unknown						

Yes No Unknown

78. 1 0 8 Smoked within past year

1 0 8 Smoked prior to but not during past year

Average number of packs per day: [][] . [][] Unknown

81. Number of years: [][] Unknown

82. Did patient have a history of clinically significant fungal infection (documented or suspected) anytime prior to conditioning?

- 1 Yes
- 0 No
- 8 Unknown

Specify:

83. Date of onset: [][][] . [][][]

Month Day Year

84. Organism (see codes 200-260, 503 on pg 28): **F** [][][]

85. If 209, 219, 259, specify fungus: _____

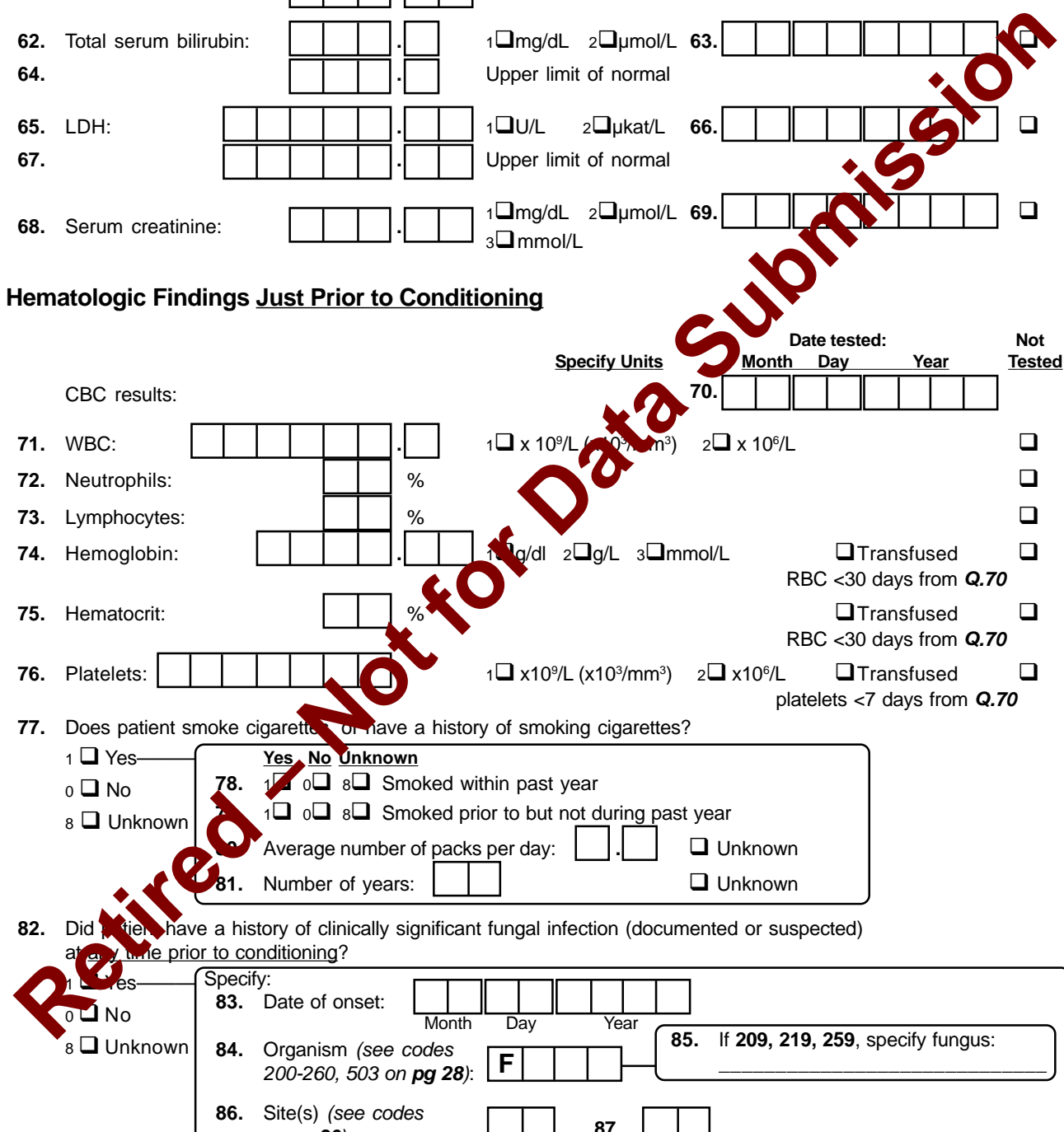
86. Site(s) (see codes on pg 30): [][] 87. [][]

88. Was there more than one documented or suspected fungal infection anytime prior to conditioning?

1 Yes

0 No

Copy Qs.83-87 and complete for each fungal infection



TEAM:

IUBMID:

Tests for Serological Evidence of Prior Viral Exposure/Infection

Recipient:

	Positive	Negative	Inconclusive	Not Tested
89. HTLV1 antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
90. Cytomegalovirus antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
91. Epstein-Barr antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
92. Hepatitis B surface antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
93. Hepatitis B core antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
94. Hepatitis B surface antigen	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
95. Hepatitis C antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
96. Hepatitis A antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
97. Human immunodeficiency virus (HIV) antibody	1 <input type="checkbox"/>	0 <input type="checkbox"/>	3 <input type="checkbox"/>	7 <input type="checkbox"/>
6 <input type="checkbox"/> Not able to release information for HIV				

Pretransplant Antitumor and Immunosuppressive Conditioning (Pretransplant conditioning)

98. Was high-dose therapy (conditioning) given?

- 1 Yes
0 No

99. Protocol requires (check only one):

- 0 All agents given as outpatient
2 Some, but not all agents given as inpatient
3 All agents given as inpatient

100. Was patient treated in an isolation room during the peri-transplant period?

- 1 Yes
0 No

Yes **No** **Unknown**

101. 1 0 8 Conventional private room
102. 1 0 8 Laminar air flow room
103. 1 0 8 HEPA filtered room
104. 1 0 8 Positive pressure
105. 1 0 8 Other

106. Specify: _____

107. Date pretransplant conditioning (radiation or drugs) was begun:

(Use earliest date from Qs.113,127,134 radiation or Qs.163-289 chemotherapy dates)

Month Day Year

108. Height at initiation of pretransplant conditioning

cm or inches

109. Actual weight at initiation of pretransplant conditioning:

kg or pounds

TEAM:

IUBMID:

110. Was irradiation performed as part of the pretransplant conditioning regimen? 1 Yes 0 No Go to Q.139

What was the radiation field?

111. Total Body Radiation

1 Yes
0 No

112. Total dose: cGy (Q.115 x Q.117)

113. Starting date:
Month Day Year

114. Was radiation fractionated?

1 Yes
0 No
8 Unknown

115. Dose per fraction: cGy
116. Number of days: (includes "rest" days)
117. Total number of fractions:

118. Was shielding used?

1 Yes
0 No
8 Unknown

Specify:
Yes No
119. 1 0 Lungs
120. 1 0 Eyes
121. 1 0 Liver
122. 1 0 Kidneys
123. 1 0 Bone
124. Specify: _____

125. Total lymphoid or nodal regions

1 Yes
0 No

126. Total dose: cGy (Q.129 x Q.131)

127. Starting date:
Month Day Year

128. Was radiation fractionated?

1 Yes
0 No
8 Unknown

129. Dose per fraction: cGy
130. Number of days: (includes "rest" days)
131. Total number of fractions:

132. Thoracic-abdominal region

1 Yes
0 No

133. Total dose: cGy (Q.136 x Q.138)

134. Starting date:
Month Day Year

135. Was radiation fractionated?

1 Yes
0 No
8 Unknown

136. Dose per fraction: cGy
137. Number of days: (includes "rest" days)
138. Total number of fractions:

Retired - Not for Data Submission

TEAM:

IUBMID:

139. Was (additional) radiation given to other sites within 14 days of preparative regimen?

1 Yes
0 No

	Yes	No	Total Dose		Date Started: (Month	Day	Year)
140. CNS	<input type="checkbox"/>	<input type="checkbox"/>	141. <input type="text"/>	cGy	142.	<input type="text"/>	<input type="text"/>
143. Gonadal	<input type="checkbox"/>	<input type="checkbox"/>	144. <input type="text"/>	cGy	145.	<input type="text"/>	<input type="text"/>
146. Splenic	<input type="checkbox"/>	<input type="checkbox"/>	147. <input type="text"/>	cGy	148.	<input type="text"/>	<input type="text"/>
149. Radiation to site of residual tumor	<input type="checkbox"/>	<input type="checkbox"/>	150. <input type="text"/>	cGy	151.	<input type="text"/>	<input type="text"/>
152. Specify site: _____							
153. Other	<input type="checkbox"/>	<input type="checkbox"/>	154. <input type="text"/>	cGy	155.	<input type="text"/>	<input type="text"/>
156. Specify site: _____							

157. Was the recipient transplanted on a protocol with a conditioning regimen intended to be non-myeloablative (NST)?

1 Yes 0 No

158. Were drugs given for pretransplant conditioning?

1 Yes 0 No [Go to Q.290](#)

Drug given	Yes	No	Total dose pre-marrow infusion (not daily dose)		Date started: (month	day	year)	Unk
159. ALG, ALS, ATG, ATS	<input type="checkbox"/>	<input type="checkbox"/>	162. <input type="text"/>	mg	163.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
160. Source: 1 <input type="checkbox"/> Horse 2 <input type="checkbox"/> Rabbit 3 <input type="checkbox"/> Other, 161. Specify: _____								
164. Anthracycline	<input type="checkbox"/>	<input type="checkbox"/>						
165. Daunomycin	<input type="checkbox"/>	<input type="checkbox"/>	166. <input type="text"/>	mg	167.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
168. Doxorubicin (Adriamycin)	<input type="checkbox"/>	<input type="checkbox"/>	169. <input type="text"/>	mg	170.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
171. Idarubicin	<input type="checkbox"/>	<input type="checkbox"/>	172. <input type="text"/>	mg	173.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
174. Rubidazole	<input type="checkbox"/>	<input type="checkbox"/>	175. <input type="text"/>	mg	176.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
177. Other anthracycline, 178. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	179. <input type="text"/>	mg	180.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
181. Bleomycin	<input type="checkbox"/>	<input type="checkbox"/>	182. <input type="text"/>	mg	183.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
184. Busulfan (myleran)	<input type="checkbox"/>	<input type="checkbox"/>						
185. <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Oral & IV								
188. Carboplatin	<input type="checkbox"/>	<input type="checkbox"/>	189. <input type="text"/>	mg	190.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
191. Cisplatin	<input type="checkbox"/>	<input type="checkbox"/>	192. <input type="text"/>	mg	193.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
194. Gemtuzumab	<input type="checkbox"/>	<input type="checkbox"/>	195. <input type="text"/>	mg	196.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
197. Corticosteroids (excluding antiemetic medication)	<input type="checkbox"/>	<input type="checkbox"/>						
198. Methylprednisolone (Solumedrol)	<input type="checkbox"/>	<input type="checkbox"/>						
199. <input type="checkbox"/> Oral <input type="checkbox"/> IV								
202. Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	203. <input type="text"/>	mg	204.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
205. Dexamethasone	<input type="checkbox"/>	<input type="checkbox"/>	206. <input type="text"/>	mg	207.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
208. Other corticosteroids, 209. Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	210. <input type="text"/>	mg	211.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Continued on next page

TEAM:

IUBMID:

Continued from previous page

Drug given	Yes No		Total dose pre-marrow infusion (not daily dose)				Date started: (month day year)			Unk		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
212. Cyclophosphamide	<input type="checkbox"/>	<input type="checkbox"/>	213.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	214.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
215. Cytarabine (Ara-C)	<input type="checkbox"/>	<input type="checkbox"/>	216.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	217.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
218. Etoposide (VP-16)	<input type="checkbox"/>	<input type="checkbox"/>	219.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	220.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
221. Fludarabine	<input type="checkbox"/>	<input type="checkbox"/>	222.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	223.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
224. Ifosfamide	<input type="checkbox"/>	<input type="checkbox"/>	225.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	226.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
227. Intrathecal chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>										
228. IT Cytarabine	<input type="checkbox"/>	<input type="checkbox"/>	229.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	230.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
231. IT Methotrexate	<input type="checkbox"/>	<input type="checkbox"/>	232.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	233.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
234. Other IT,	<input type="checkbox"/>	<input type="checkbox"/>	236.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	237.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
235. Specify: _____												
238. Gleevec (STI571, imatinib mesylate)	<input type="checkbox"/>	<input type="checkbox"/>	239.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	240.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
241. Melphalan (L-PAM)	<input type="checkbox"/>	<input type="checkbox"/>										
242. <input type="checkbox"/> Oral <input type="checkbox"/> IV												
243.	<input type="checkbox"/>	<input type="checkbox"/>	243.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	244.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
245. Mitoxantrone	<input type="checkbox"/>	<input type="checkbox"/>	246.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	247.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
248. Monoclonal antibody	<input type="checkbox"/>	<input type="checkbox"/>										
249. Radio labeled Mab	<input type="checkbox"/>	<input type="checkbox"/>	251.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	252.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
250. Specify: _____												
253. Campath	<input type="checkbox"/>	<input type="checkbox"/>	254.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	255.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
256. Rituxan (Anti CD20)	<input type="checkbox"/>	<input type="checkbox"/>	257.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	258.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
259. Mylotarg (Gemtuzumab)	<input type="checkbox"/>	<input type="checkbox"/>	260.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	261.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
262. Other Mab,	<input type="checkbox"/>	<input type="checkbox"/>	264.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	265.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
263. Specify: _____												
266. Nitrosourea	<input type="checkbox"/>	<input type="checkbox"/>										
267. ICN	<input type="checkbox"/>	<input type="checkbox"/>	268.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	269.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
270. CCNU	<input type="checkbox"/>	<input type="checkbox"/>	271.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	272.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
273. Other nitrosourea,	<input type="checkbox"/>	<input type="checkbox"/>	275.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	276.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
274. Specify: _____												
277. Paclitaxel (Taxol)	<input type="checkbox"/>	<input type="checkbox"/>	278.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	279.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
280. Teniposide (VM26)	<input type="checkbox"/>	<input type="checkbox"/>	281.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	282.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
283. Thiotepa	<input type="checkbox"/>	<input type="checkbox"/>	284.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	285.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
286. Other,	<input type="checkbox"/>	<input type="checkbox"/>	288.	<input type="text"/>	<input type="text"/>	<input type="text"/>	mg	289.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
287. Specify: _____												

Retired - Not for Data Submission

End of Pretransplant Data

TEAM:

IUBMID:

290. Was this the first HSCT for this recipient?

- 1 Yes
- 0 No

291. Is a second HSCT planned as part of treatment protocol? 1 Yes 0 No

Go to Q.304

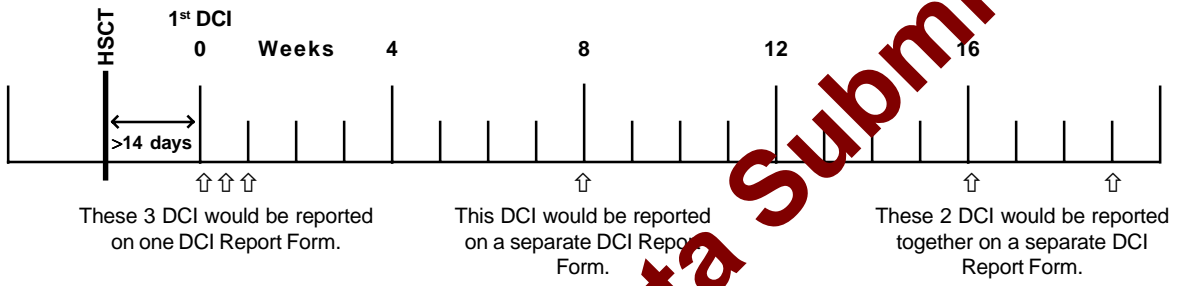
Previous Transplants

292. Number of previous HSCT/DCI patient has had:

293. Date of most recent previous HSCT/DCI:
Month Day Year

DCI Calculation Timeline

Some patients have cellular infusions on more than one day. A single DCI form should be completed for all infusions given within a 4-week period starting from the date of the first DCI >14 days following a HSCT or >28 days post prior DCI. Separate DCI Report Forms should be completed for subsequent infusion(s) given after this 4-week period. For example:



Strat Fig A-53

294. Was previous transplant performed at a different institution?

- 1 Yes
- 0 No

295. Specify:
 Name: _____
 City: _____ State: _____
 Country: _____

296. Indicate graft type of previous transplant (check only one):

- 1 Autologous
- 2 Allogeneic, unrelated donor
- 3 Syngeneic or allogeneic, related donor

297. Was this transplant reported to the ABMTR?
 1 Yes 0 No 8 Unknown

298. Was same donor as current?
 1 Yes 0 No

299. Was this transplant reported to the IBMTR?
 1 Yes 0 No 8 Unknown

300. Reason for re-transplant (check only one):

- 1 No engraftment
- 2 Partial engraftment
- 3 Graft failure/rejection
- 4 Persistent malignancy
- 5 Recurrent malignancy
- 6 Planned second HSCT/DCI, per protocol
- 8 Secondary malignancy (including PTLN, EBV Lymphoma)
(specify disease from lists on pgs 2-5):
- 9 Stable, mixed chimerism
- 10 Declining chimerism
- 90 Other, 303. specify: _____

301. Date of rejection/failure:
Month Day Year

302. Date of relapse:
Month Day Year

Continue with disease insert for disease of first transplant

Retired - Not for Data Submission

TEAM:

IUBMID:

304. What type of graft did patient receive (or was planned) for the current transplant (*check only one*)?

1 <input type="checkbox"/> Autologous	From where were stem cells obtained?	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	305. <input type="checkbox"/> Bone marrow	<i>If yes, complete INSERT AUTOBM</i>
	306. <input type="checkbox"/> Blood	<i>If yes, complete INSERT AUTOPB</i>
2 <input type="checkbox"/> Allogeneic	From where were stem cells obtained?	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3 <input type="checkbox"/> Syngeneic	307. <input type="checkbox"/> Bone marrow	<i>If yes, complete Inserts ALLOBM</i>
	308. <input type="checkbox"/> Peripheral blood	<i>If yes, complete Inserts ALLOPB</i>
	309. <input type="checkbox"/> Umbilical cord blood	<i>If yes, complete Inserts ALLOCB</i>
	310. <input type="checkbox"/> Fetal tissue	<i>If yes, complete Inserts ALLOBM</i>
	311. <input type="checkbox"/> Other, _____	<i>If yes, complete Inserts ALLOBM</i>
		312. Specify: _____
	313. <input type="checkbox"/> Donor Cellular Infusion	<i>If yes, complete Day 100 DCI Report Form, not this Report Form</i>

314. Did patient receive graft?

- 1 Yes
0 No

315. Reason (<i>check only one</i>):
1 <input type="checkbox"/> Patient died between first dose of conditioning and HSCT
2 <input type="checkbox"/> Transplant cancelled, but patient was alive, 316. specify reason: _____

Retired – Not for Data Submission

TEAM:

IUBMID:

Post-HSCT Information

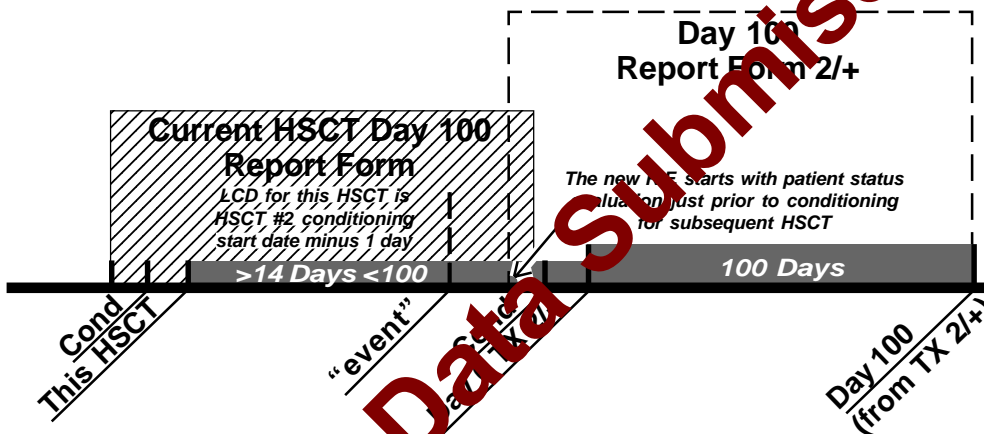
317. Did patient receive a subsequent HSCT after the HSCT for which this Report Form is being completed?

- 1 Yes
- 0 No
- 8 Unknown

event = The reason for subsequent allo HSCT (planned, to treat relapse, for graft failure, etc.)
LCD = last contact date, also represents cut-off date for data included in the Report Form
Cond = Conditioning

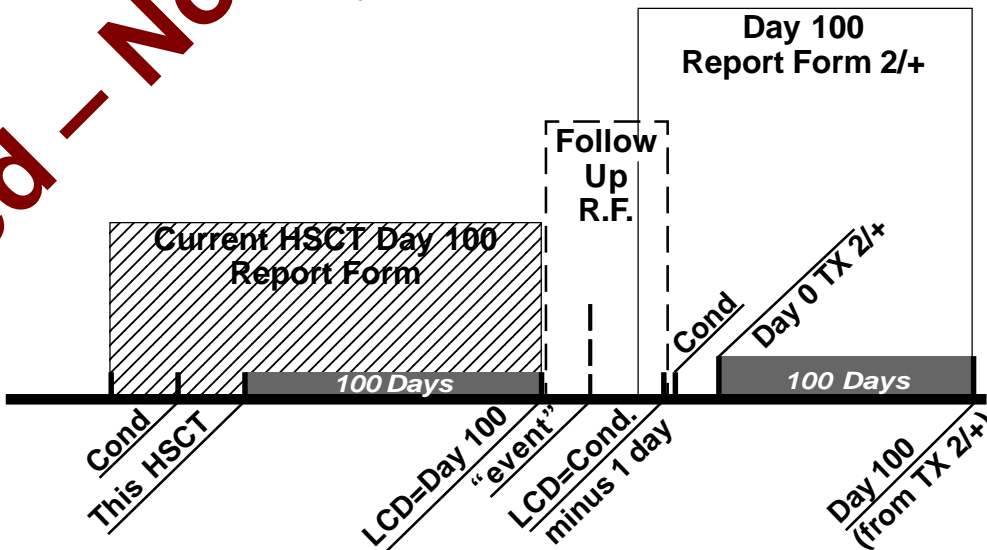
>14 Days but <100 days between HSCT & Subsequent HSCT

Answers to Pgs 17-36 should reflect clinical status up to start of conditioning for HSCT minus 1 day. Be sure to answer Qs.753-759 on pg 34 of this Report Form.



>100 days between HSCT & Subsequent HSCT

Complete Follow-up Report Form to cover events occurring >100 days after HSCT up to conditioning for HSCT minus 1 day. Be sure to answer Qs. 753-759 on pg 34 of this Report Form.



Retired - Not for Data Submission

Strd Fig A-60

TEAM:

IUBMID:

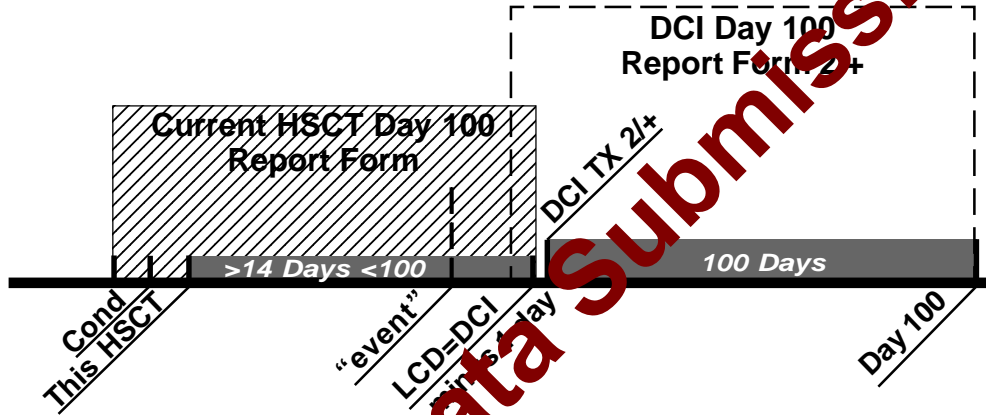
318. Has patient received (from the original donor) a subsequent DCI that requires reporting on a separate DCI form based on the DCI Calculation Timeline (see pg 13)?

- 1 Yes
- 0 No
- 8 Unknown

event = The reason for subsequent DCI (planned, to treat relapse, etc.)
LCD = last contact date, also represents cut-off date for data included in the Report Form

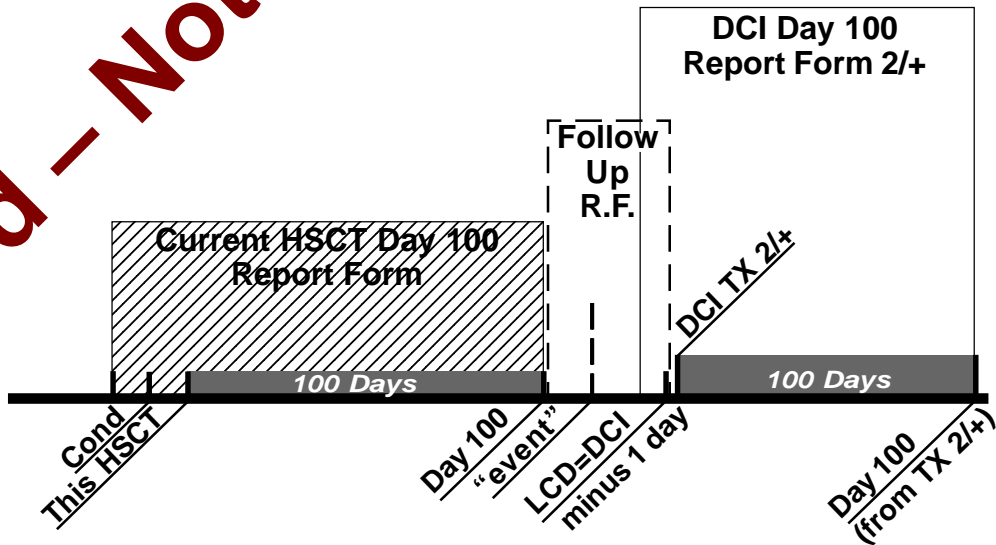
>14 Days but <100 days between HSCT and DCI

Answers to Pgs 17-36 should reflect clinical status up to subsequent DCI minus 1 day.
Be sure to answer Qs.760-763 on pg 35 of this Report Form.



>100 days between HSCT and DCI

Complete Follow-up Report Form to cover events >100 days after current HSCT and up to first infusion of subsequent DCI minus 1 day.
Be sure to answer Qs. 760-763 on pg 35 of this Report Form.



Stand Fig A-61

Retired - Not for Data Submission

TEAM:

IUBMID:

319. Indicate survival status at last contact date (approximately Day 100 if no subsequent HSCT/DCI) for this Report Form:

0 Alive

320. Did recipient have a subsequent reportable HSCT/DCI before Day 100?
1 Yes, answers on **pgs 17-35** should reflect clinical status up to 1 day prior to conditioning/DCI
0 No, answers on **pgs 17-33** should reflect clinical status on day of actual contact for this report, at least 100 days post-DCI

1 Deceased – Recipient did not have a subsequent reportable HSCT/DCI
(Answers on **Pgs 17-36** should reflect clinical status up to date of death)

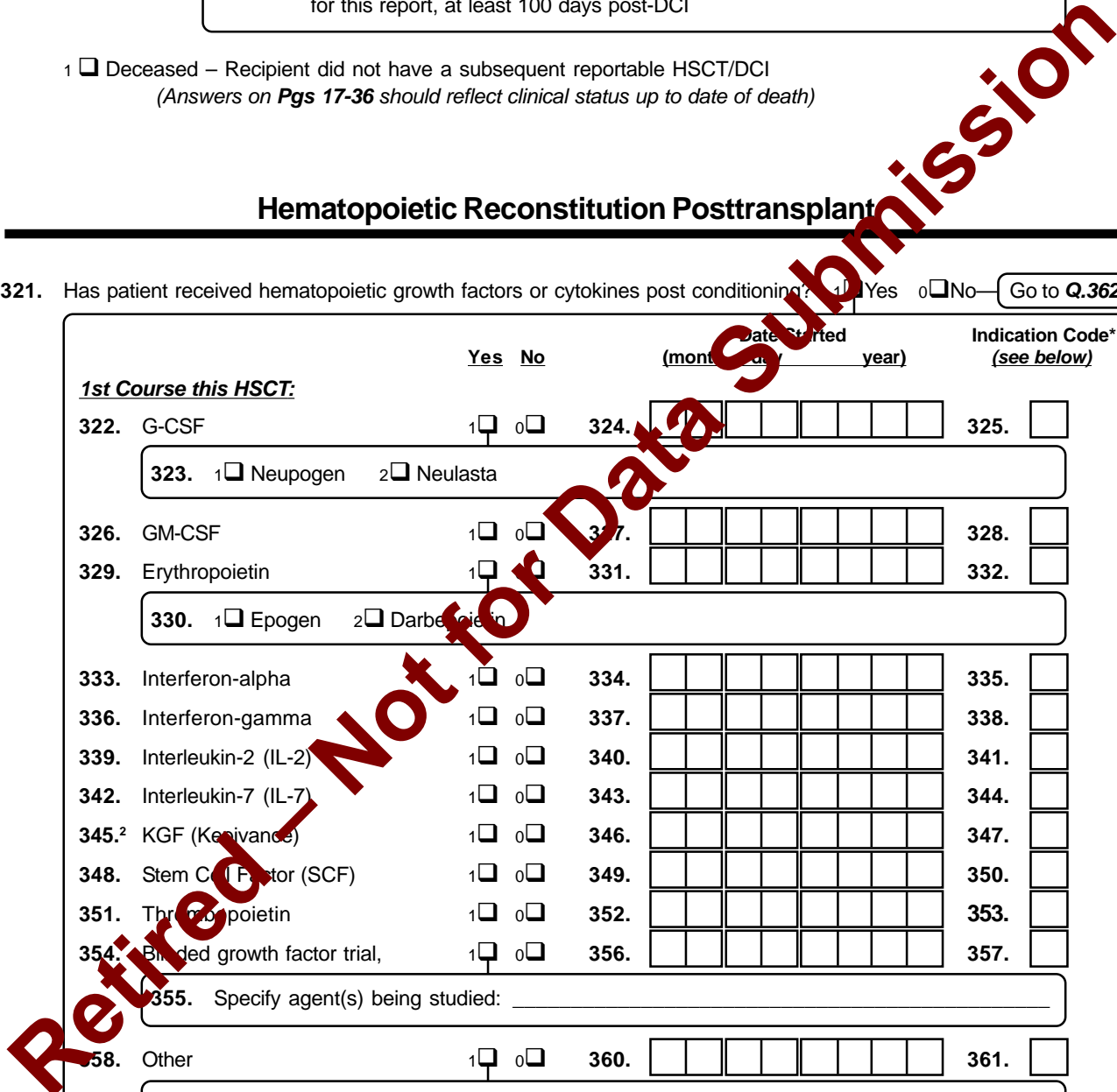
Hematopoietic Reconstitution Posttransplant

321. Has patient received hematopoietic growth factors or cytokines post conditioning? 1 Yes 0 No Go to Q.362

		Yes	No	Date Started (month day year)				Indication Code* (see below)	
1st Course this HSCT:									
322.	G-CSF	1 <input type="checkbox"/>	0 <input type="checkbox"/>	324.	<input type="text"/>	<input type="text"/>	<input type="text"/>	325.	<input type="text"/>
323.		1 <input type="checkbox"/> Neupogen 2 <input type="checkbox"/> Neulasta							
326.	GM-CSF	1 <input type="checkbox"/>	0 <input type="checkbox"/>	327.	<input type="text"/>	<input type="text"/>	<input type="text"/>	328.	<input type="text"/>
329.	Erythropoietin	1 <input type="checkbox"/>	0 <input type="checkbox"/>	331.	<input type="text"/>	<input type="text"/>	<input type="text"/>	332.	<input type="text"/>
330.		1 <input type="checkbox"/> Epogen 2 <input type="checkbox"/> Darbepoetin							
333.	Interferon-alpha	1 <input type="checkbox"/>	0 <input type="checkbox"/>	334.	<input type="text"/>	<input type="text"/>	<input type="text"/>	335.	<input type="text"/>
336.	Interferon-gamma	1 <input type="checkbox"/>	0 <input type="checkbox"/>	337.	<input type="text"/>	<input type="text"/>	<input type="text"/>	338.	<input type="text"/>
339.	Interleukin-2 (IL-2)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	340.	<input type="text"/>	<input type="text"/>	<input type="text"/>	341.	<input type="text"/>
342.	Interleukin-7 (IL-7)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	343.	<input type="text"/>	<input type="text"/>	<input type="text"/>	344.	<input type="text"/>
345. ²	KGF (Kepivance)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	346.	<input type="text"/>	<input type="text"/>	<input type="text"/>	347.	<input type="text"/>
348.	Stem Cell Factor (SCF)	1 <input type="checkbox"/>	0 <input type="checkbox"/>	349.	<input type="text"/>	<input type="text"/>	<input type="text"/>	350.	<input type="text"/>
351.	Thrombopoietin	1 <input type="checkbox"/>	0 <input type="checkbox"/>	352.	<input type="text"/>	<input type="text"/>	<input type="text"/>	353.	<input type="text"/>
354.	Blinded growth factor trial,	1 <input type="checkbox"/>	0 <input type="checkbox"/>	356.	<input type="text"/>	<input type="text"/>	<input type="text"/>	357.	<input type="text"/>
355.		Specify agent(s) being studied: _____							
358.	Other	1 <input type="checkbox"/>	0 <input type="checkbox"/>	360.	<input type="text"/>	<input type="text"/>	<input type="text"/>	361.	<input type="text"/>
359.		Specify: _____							

***Coding for Indication of Therapy**

0 = Planned therapy per protocol to promote engraftment	4 = Intervention for delay/decline in red blood cell counts
1 = Intervention for delay/decline in Absolute Neutrophil Count (ANC)	5 = Anti-leukemic or tumor agent to <u>prevent</u> relapse
2 = Intervention for delay/decline in platelets	6 = Anti-leukemic or tumor agent to <u>treat</u> relapse
3 = Intervention for delay/decline in both ANC and platelets	7 = Other indication



TEAM:

IUBMID:

Granulopoiesis*

* All dates should reflect the first of 3 consecutive lab results on different days

362. Is/Was there evidence of hematopoietic recovery following the initial hematopoietic cell infusion?

(check only one)

1 Yes, ANC $\geq 500/\text{mm}^3$ achieved and sustained for 3 consecutive lab values* with no subsequent decline

363. Date ANC $\geq 500/\text{mm}^3$ (first of 3 consecutive lab values*):
Month Day Year

2 Yes, ANC $\geq 500/\text{mm}^3$ for 3 consecutive lab values* with subsequent decline in ANC to $< 500/\text{mm}^3$ for greater than 3 consecutive lab values*

364. Date ANC $\geq 500/\text{mm}^3$ (first of 3 consecutive lab values*):
Month Day Year

365. Date of decline in ANC to $< 500/\text{mm}^3$ for greater than 3 lab values* (first of 3 lab values* that ANC remained < 500):
Month Day Year

3 No, ANC $\geq 500/\text{mm}^3$ was not achieved and there was no evidence of recurrent disease in the bone marrow

CBC on first day of decline:

366. WBC: $\times 10^9/\text{L}$ $\times 10^6/\text{L}$

367. Neutrophils: %

4 No, ANC $\geq 500/\text{mm}^3$ was not achieved and there was documented persistent disease in the bone marrow

368. Did patient recover and maintain ANC $\geq 500/\text{mm}^3$ following the decline without a subsequent allo transplant/infusion?

1 Yes
0 No

369. Date of ANC recovery:
Month Day Year Date unknown

370. WBC: $\times 10^9/\text{L}$ $\times 10^6/\text{L}$

371. Neutrophils: %

7 ANC never dropped below $500/\text{mm}^3$ at anytime post conditioning

Retired - Not for Data Submission

TEAM:

IUBMID:

Megakaryopoiesis*

**The following questions relate to initial platelet recovery. All dates should reflect no transfusions in previous 7 days, and the first of 3 consecutive laboratory results tested on different days.*

372. Was a platelet count of $\geq 20 \times 10^9/L$ achieved?

- 1 Yes
- 0 No
- 7 Never dropped below 20
- 8 Unknown

Go to **Q.376**

373. Date platelets $\geq 20 \times 10^9/L$ (first of 3 consecutive labs, no platelet transfusions 7 days prior):

Month Day Year

- Date estimated
- Date unknown

374. Was a platelet count of $\geq 50 \times 10^9/L$ achieved?

- 1 Yes
- 0 No
- 7 Never dropped below 50
- 8 Unknown

375. Date platelets $\geq 50 \times 10^9/L$ (first of 3 consecutive labs, no platelet transfusions 7 days prior):

Month Day Year

- Date estimated
- Date unknown

Current Hematologic Findings

		Date of most recent test:			Not	
		Month	Day	Year	Tested	
CBC results:		376.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
377. WBC:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	1 <input type="checkbox"/> x 10 ⁹ /L (x10 ³ /mm ³)	2 <input type="checkbox"/> x 10 ⁶ /L			<input type="checkbox"/>
378. Neutrophils:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> %					<input type="checkbox"/>
379. Lymphocytes:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> %					<input type="checkbox"/>
380. Hemoglobin:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1 <input type="checkbox"/> g/dl	2 <input type="checkbox"/> g/L	3 <input type="checkbox"/> mmol/L	<input type="checkbox"/> Transfused	<input type="checkbox"/>
					RBC <30 days from Q.376	
381. Hematocrit:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> %				<input type="checkbox"/> Transfused	<input type="checkbox"/>
					RBC <30 days from Q.376	
382. Platelets:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1 <input type="checkbox"/> x10 ⁹ /L (x10 ³ /mm ³)	2 <input type="checkbox"/> x10 ⁶ /L		<input type="checkbox"/> Transfused	<input type="checkbox"/>
					platelets <7 days from Q.376	

Retired - Not for Data Submission

TEAM:

IUBMID:

Acute Graft-vs-Host Disease (GVHD)

383. Was specific therapy used post conditioning to prevent or induce acute GVHD, or promote engraftment (other than growth factors reported in Q.321)?

1 Yes

0 No

Allografts, go to Q.410
Autografts, go to Q.564

	Yes	No																												
384.	<input type="checkbox"/>	<input type="checkbox"/>	ALS, ALG, ATS, ATG																											
385. Source: 1 <input type="checkbox"/> Horse 2 <input type="checkbox"/> Rabbit 3 <input type="checkbox"/> Other, 386. Specify: _____																														
387.	<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroids (systemic)																											
388.	<input type="checkbox"/>	<input type="checkbox"/>	Cyclosporine (CSA) (e.g., Sandimmune, Neoral)																											
389.	<input type="checkbox"/>	<input type="checkbox"/>	ECP (extra-corporeal photopheresis)																											
390.	<input type="checkbox"/>	<input type="checkbox"/>	FK 506 (e.g., Tacrolimus, Prograf)																											
391.	<input type="checkbox"/>	<input type="checkbox"/>	In vivo monoclonal antibody																											
392. <table border="1"><thead><tr><th>Yes</th><th>No</th><th></th></tr></thead><tbody><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anti CD 25 (e.g., Zelenapax, Daclizumab, AntiTAC)</td></tr><tr><td colspan="3">393. Specify: _____</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Campath</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Etanercept (Enbrel)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Infliximab (Remicade)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>IL-2/3 (e.g., Orthoclone)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td colspan="3">399. Specify: _____</td></tr></tbody></table>				Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Anti CD 25 (e.g., Zelenapax, Daclizumab, AntiTAC)	393. Specify: _____			<input type="checkbox"/>	<input type="checkbox"/>	Campath	<input type="checkbox"/>	<input type="checkbox"/>	Etanercept (Enbrel)	<input type="checkbox"/>	<input type="checkbox"/>	Infliximab (Remicade)	<input type="checkbox"/>	<input type="checkbox"/>	IL-2/3 (e.g., Orthoclone)	<input type="checkbox"/>	<input type="checkbox"/>	Other	399. Specify: _____		
Yes	No																													
<input type="checkbox"/>	<input type="checkbox"/>	Anti CD 25 (e.g., Zelenapax, Daclizumab, AntiTAC)																												
393. Specify: _____																														
<input type="checkbox"/>	<input type="checkbox"/>	Campath																												
<input type="checkbox"/>	<input type="checkbox"/>	Etanercept (Enbrel)																												
<input type="checkbox"/>	<input type="checkbox"/>	Infliximab (Remicade)																												
<input type="checkbox"/>	<input type="checkbox"/>	IL-2/3 (e.g., Orthoclone)																												
<input type="checkbox"/>	<input type="checkbox"/>	Other																												
399. Specify: _____																														
400.	<input type="checkbox"/>	<input type="checkbox"/>	In vivo immunotoxin																											
401. Specify: _____																														
402.	<input type="checkbox"/>	<input type="checkbox"/>	Methotrexate (MTX) (e.g., Amethopterin)																											
403.	<input type="checkbox"/>	<input type="checkbox"/>	Mycophenolate mofetil (MMF) (e.g., Cellcept)																											
404.	<input type="checkbox"/>	<input type="checkbox"/>	Sirolimus (e.g., Rapamycin, Rapamune)																											
405.	<input type="checkbox"/>	<input type="checkbox"/>	Ursodiol																											
406.	<input type="checkbox"/>	<input type="checkbox"/>	Blinded randomized trial																											
407. Specify agent(s) being studied: _____																														
408.	<input type="checkbox"/>	<input type="checkbox"/>	Other																											
409. Specify: _____																														

Retired - Not for Data Submission

TEAM:

IUBMID:

410. Did acute GVHD occur?

- 1 Yes
- 2 Acute GVHD persists from prior HSCT/DCI
- 0 No
- 8 Unknown

Go to **Q.470**

411. Maximum overall grade: 1 I 2 II 3 III 4 IV

412. What was diagnosis based on?
1 Histologic evidence
2 Clinical evidence
3 Both
8 Unknown

413. Date of onset:
Month Day Year

414. Is acute GVHD still present at last contact date for this Report Form?
1 Yes
0 No
2 Progressed to chronic GVHD
8 Unknown

List the maximum severity of organ involvement attributed to acute GVHD:

	<u>Stage 0</u>	<u>Stage 1</u>	<u>Stage 2</u>	<u>Stage 3</u>	<u>Stage 4</u>
415. Skin:	0 <input type="checkbox"/> No skin GVHD 1 <input type="checkbox"/> No rash	2 <input type="checkbox"/> Maculopapular rash, <25% of body surface	3 <input type="checkbox"/> Maculopapular rash, 25-50% of body surface	4 <input type="checkbox"/> Generalized erythroderma	5 <input type="checkbox"/> Generalized erythroderma with bullae formation and desquamation
416. Intestinal tract (use ml/day for adult patients and ml/m²/day for pediatric patients):	0 <input type="checkbox"/> No gut GVHD 1 <input type="checkbox"/> Diarrhea ≤500 ml/day or <280 ml/m ² /day	2 <input type="checkbox"/> Diarrhea >500 but ≤1000 ml/day or >280-555 ml/m ² /day	3 <input type="checkbox"/> Diarrhea >1000 but ≤1500 ml/day or 556-833 ml/m ² /day	4 <input type="checkbox"/> Diarrhea >1500 ml/day or >833 ml/m ² /day	5 <input type="checkbox"/> Severe abdominal pain, with or without ileus
417. Liver:	0 <input type="checkbox"/> Bilirubin evaluated, not attributed to GVHD (captured in Q.693) 1 <input type="checkbox"/> Bilirubin <2.0 mg/dL or <34 μmol/L	2 <input type="checkbox"/> Bilirubin 2.0-3.0 mg/dL or 34-52 μmol/L	3 <input type="checkbox"/> Bilirubin 3.1-6.0 mg/dL or 53-103 μmol/L	4 <input type="checkbox"/> Bilirubin 6.1-15.0 mg/dL or 104-256 μmol/L	5 <input type="checkbox"/> Bilirubin >15.0 mg/dL or >256 μmol/L
418. Other organ involvement?	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No				
419.	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No Upper GI tract				
420.	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No Lung				
421.	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No Other				
422.	Specify: <input type="text"/>				

Retired - Not for Data Submission

TEAM:

IUBMID:

423. Was specific therapy used to **treat** acute GVHD? 1 Yes 0 No — **Go to Q.470**

For each agent listed below, indicate whether or not it was used to **treat** acute GVHD:

	No, drug not given	Drug continued at prophylactic dose	Yes, drug started		Yes, dose increased*	Still taking?	
			1	2		3	Yes
424. ALS, ALG, ATS, ATG	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	427.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
425. Source: 1 <input type="checkbox"/> Horse 2 <input type="checkbox"/> Rabbit 3 <input type="checkbox"/> Other, 426. Specify: _____							
428. Corticosteroids (systemic)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	429.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
430. Corticosteroids (topical)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	431.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
432. Cyclosporine (CSA) (e.g., Sandimmune, Neoral)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	432.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
434. ECP (extra-corporeal photopheresis)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	435.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
436. FK 506 (e.g., Tacrolimus, Prograf)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	437.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
438. In vivo monoclonal antibody	1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No						
439. Anti CD 25 (e.g., Zenapax, Daclizumab, AntiTAC)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	441.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
440. Specify: _____							
442. Campath	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	443.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
444. Etanercept (Enbrel)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	445.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
446. Infliximab (Remicade)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	447.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
448. OKT3 (e.g., Orthoclone)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	449.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
450. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	452.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
451. Specify antibody: _____							
453. In vivo immunotoxin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	455.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
454. Specify: _____							
456. Methotrexate (MTX) (e.g., Arithropterin)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	457.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
458. Mycophenolate mofetil (MMF) (e.g., Cellcept)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	459.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
460. Sirolimus (e.g., Rapamycin, Rapamune)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	461.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
462. Ursodiol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	463.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
464. Blinded randomized trial	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	466.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
465. Specify agent being studied: _____							
467. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	469.	1 <input type="checkbox"/>	0 <input type="checkbox"/>
468. Specify: _____							

Retired - Not for Data Submission

* for a therapeutic purpose

TEAM:

IUBMID:

Chronic Graft-vs-Host Disease (GVHD)

470. Has patient developed clinical chronic GVHD?

1 Yes

0 No

8 Unknown

Go to

Q.564

471. Date of onset:
Month Day Year

Date unknown (Q.472 = #)

472. Onset of chronic GVHD was (check only one):

1 Progressive (acute GVHD progressed directly to chronic GVHD)

2 Interrupted (acute GVHD resolved, then chronic GVHD developed)

3 De novo (never developed acute GVHD)

4 Chronic GVHD flair (symptoms reactivate within 30 days of drug tapering or discontinuation)

473. Karnofsky/Lansky score at diagnosis of chronic GVHD: (see pg 6 for scores)

474. Platelet count at diagnosis of chronic GVHD:

Specify units for platelet count: 1 $\times 10^9/L$ ($\times 10^3/mm^3$) 2 $\times 10^6/L$

475. Total serum bilirubin at diagnosis of chronic GVHD:

Specify units for bilirubin: 1 mg/dL 2 $\mu mol/L$

476. Diagnosis based on:

1 Histologic evidence

2 Clinical evidence

3 Both

8 Unknown

477. Maximum grade of chronic GVHD:

1 Limited - localized skin involvement and/or hepatic dysfunction due to chronic GVHD

2 Extensive - one or more of the following:

-generalized skin involvement; or,

-Liver histology showing chronic aggressive hepatitis, bridging necrosis or cirrhosis; or,

-Involvement of eye: Schirmer's test with <5 mm wetting; or,

-Involvement of minor salivary glands or oral mucosa demonstrated on labial biopsy; or,

-Involvement of any other target organ

478. Overall severity:

1 Mild - signs and symptoms of chronic GVHD do not interfere substantially with function and do not progress once appropriately treated with local therapy or standard systemic therapy (corticosteroids)

2 Moderate - signs and symptoms of chronic GVHD interfere somewhat with function despite appropriate therapy or are progressive through first line systemic therapy (corticosteroids)

3 Severe - signs and symptoms of chronic GVHD limit function substantially despite appropriate therapy or are progressive through second line therapy

Continued on next page

TEAM:

IUBMID:

Continued from previous page

Indicate organ involvement with chronic GVHD from list below:

	Absent	Present	Unknown	
Skin/Hair: 479.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Subclinical (biopsy findings only)——See Q.476, #1
480.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash
481.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma
482.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lichenoid skin changes
483.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dyspigmentation
484.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alopecia
485.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body surface area
486.				Specific percent of BSA involved: <input type="text"/> <input type="text"/> %
487.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other skin/hair involvement, 488. Specify: _____
Eyes: 489.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
490.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Schirmer's test
491.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Corneal erosion/conjunctivitis
492.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other eye involvement 493. Specify: _____
Mouth: 494.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lichenoid changes
495.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucositis/Ulcers
496.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other mouth involvement, 497. Specify: _____
Lung: 498.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonitis obliterans (BO, BOOP)——See Q.673
499.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other lung involvement 500. Specify: _____
GI Tract: 501.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal involvement
502.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic nausea/Vomiting
503.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea
504.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malabsorption
505.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain/cramps
506.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other GI tract involvement 507. Specify: _____
Liver: 508.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver involvement 509. Specify: _____
GU Tract: 510.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginitis/Stricture
511.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other GU involvement 512. Specify: _____
Musculoskeletal: 513.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
514.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contractures
515.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myositis
516.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia
517.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other musculoskeletal involvement 518. Specify: _____
Hematologic: 519.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia
520.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eosinophilia
521.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoantibodies
522.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other hematologic involvement 523. Specify: _____
Other: 524.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serositis 525. Specify site: _____
526.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss
527.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other 528. Specify: _____

Retired - Not for Data Submission

TEAM:

IUBMID:

529. Were specific agents used to **treat** chronic GVHD?

- 1 Yes
- 0 No

Go to **Q.563**

	No, drug not given	Drug continued from prophylaxis/aGVHD treatment	Yes, drug started
530. ALS, ALG, ATS, ATG	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
531. Source: 1 <input type="checkbox"/> Horse 2 <input type="checkbox"/> Rabbit 3 <input type="checkbox"/> Other, 532. Specify: _____			
533. Azathioprine	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
534. Corticosteroids (systemic)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
535. Corticosteroids (topical)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
536. Cyclosporine (CSA) (e.g., Sandimmune, Neoral)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
537. ECP (extra-corporeal photopheresis)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
538. Etretinate	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
539. FK 506 (e.g., Tacrolimus, Prograf)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
540. Hydroxychloroquine (Plaquenil)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
541. In vivo monoclonal antibody			
1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No			
542. Anti CD 25 (e.g., Zenapax, Daclizumab, AntiTAC)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
543. Specify: _____			
544. Campath	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
545. Etanercept (Enbrel)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
546. Infliximab (Remicade)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
547. OKT3 (e.g., Orthoclone)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
548. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
549. Specify: _____			
550. Lamprene (Cofarimine)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
551. Mycophenolate mofetil (MMF) (e.g., Cellcept)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
552. Pento Statin	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
553. PUVA (Psoralen and UVA)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
554. Sirolimus (e.g., Rapamycin, Rapamune)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
555. Thalidomide	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
556. Ursodiol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
557. Blinded randomized trial	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
558. Specify agent being studied: _____			
559. Other	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
560. Specify: _____			

561. Is patient still receiving immuno-suppressive agents (including PUVA) to treat/prevent cGVHD?

- 1 Yes
- 0 No
- 8 Unknown

562. Date last treatment was administered: Unknown
Month Day Year

563. Are symptoms of chronic GVHD still present (or present at time of death)? 1 Yes 0 No

TEAM:

IUBMID:

Other Treatment and Clinical Status After Start of Conditioning

564. Were transfusions given at any time after start of conditioning to 60 days post-HSCT or LCD, whichever comes sooner?

- 1 Yes
- 0 No
- 8 Unknown

		Unknown	
565.	RBC (from conditioning to 60 days post-HSCT):	<input type="text"/> <input type="text"/> <input type="text"/>	Units <input type="checkbox"/>
Platelet (from conditioning to 60 days post-HSCT):			
566.	Single donor	<input type="text"/> <input type="text"/> <input type="text"/>	Number of aphereses <input type="checkbox"/>
567.	Random donor	<input type="text"/> <input type="text"/> <input type="text"/>	Number of donors <input type="checkbox"/>
<i>(e.g., a 6 pack of donor platelets transfused at one time = 6)</i>			
568.	Irradiated granulocyte infusions (from conditioning to 60 days post-HSCT):	<input type="text"/> <input type="text"/> <input type="text"/>	Number of infusions <input type="checkbox"/>

569. Did patient receive any of the following agents for infection prophylaxis after start of conditioning?

- 1 Yes
- 0 No
- 8 Unknown

	Yes	No	
570.	<input type="checkbox"/>	<input type="checkbox"/>	Systemic antibacterial antibiotics
571.	<input type="checkbox"/>	<input type="checkbox"/>	Nonabsorbable oral antibiotics
572.	<input type="checkbox"/>	<input type="checkbox"/>	Polyclonal IV gamma globulin (e.g., IVIG, not ATG)
573.	<input type="checkbox"/>	<input type="checkbox"/>	CMV/hyperimmune gamma globulin
574.	<input type="checkbox"/>	<input type="checkbox"/>	IV amphotericin (Fungizone)
575.	<input type="checkbox"/>	<input type="checkbox"/>	IV amphotericin lipid formulation (e.g., Abelcet, AmBisome, Amphotec)
576. Specify: <input type="text"/>			
577.	<input type="checkbox"/>	<input type="checkbox"/>	Caspofungin
578.	<input type="checkbox"/>	<input type="checkbox"/>	Fluconazole
579.	<input type="checkbox"/>	<input type="checkbox"/>	Itraconazole
580.	<input type="checkbox"/>	<input type="checkbox"/>	Posaconazole
581.	<input type="checkbox"/>	<input type="checkbox"/>	Voriconazole
582.	<input type="checkbox"/>	<input type="checkbox"/>	Other systemic antifungal agent
583. Specify: <input type="text"/>			
584.	<input type="checkbox"/>	<input type="checkbox"/>	Acyclovir
585.	<input type="checkbox"/>	<input type="checkbox"/>	Ganciclovir (DHPG)
586. Specify: 1 <input type="checkbox"/> IV 2 <input type="checkbox"/> PO			
587.	<input type="checkbox"/>	<input type="checkbox"/>	Foscarnet
588.	<input type="checkbox"/>	<input type="checkbox"/>	Valacyclovir
589.	<input type="checkbox"/>	<input type="checkbox"/>	Other antiviral agent
590. Specify: <input type="text"/>			
591.	<input type="checkbox"/>	<input type="checkbox"/>	Trimethoprim-sulfamethoxazole (Bactrim/Septa)
592.	<input type="checkbox"/>	<input type="checkbox"/>	Pentamidine inhaled
593.	<input type="checkbox"/>	<input type="checkbox"/>	Pentamidine IV
594.	<input type="checkbox"/>	<input type="checkbox"/>	Dapsone
595.	<input type="checkbox"/>	<input type="checkbox"/>	Other pneumocystis prophylaxis
596. Specify: <input type="text"/>			
597.	<input type="checkbox"/>	<input type="checkbox"/>	Other
598. Specify: <input type="text"/>			

Retired - Not for Data Submission

TEAM:

IUBMID:

599. Did patient develop clinically significant infection after start of conditioning?

- 1 Yes
- 0 No
- 8 Unknown

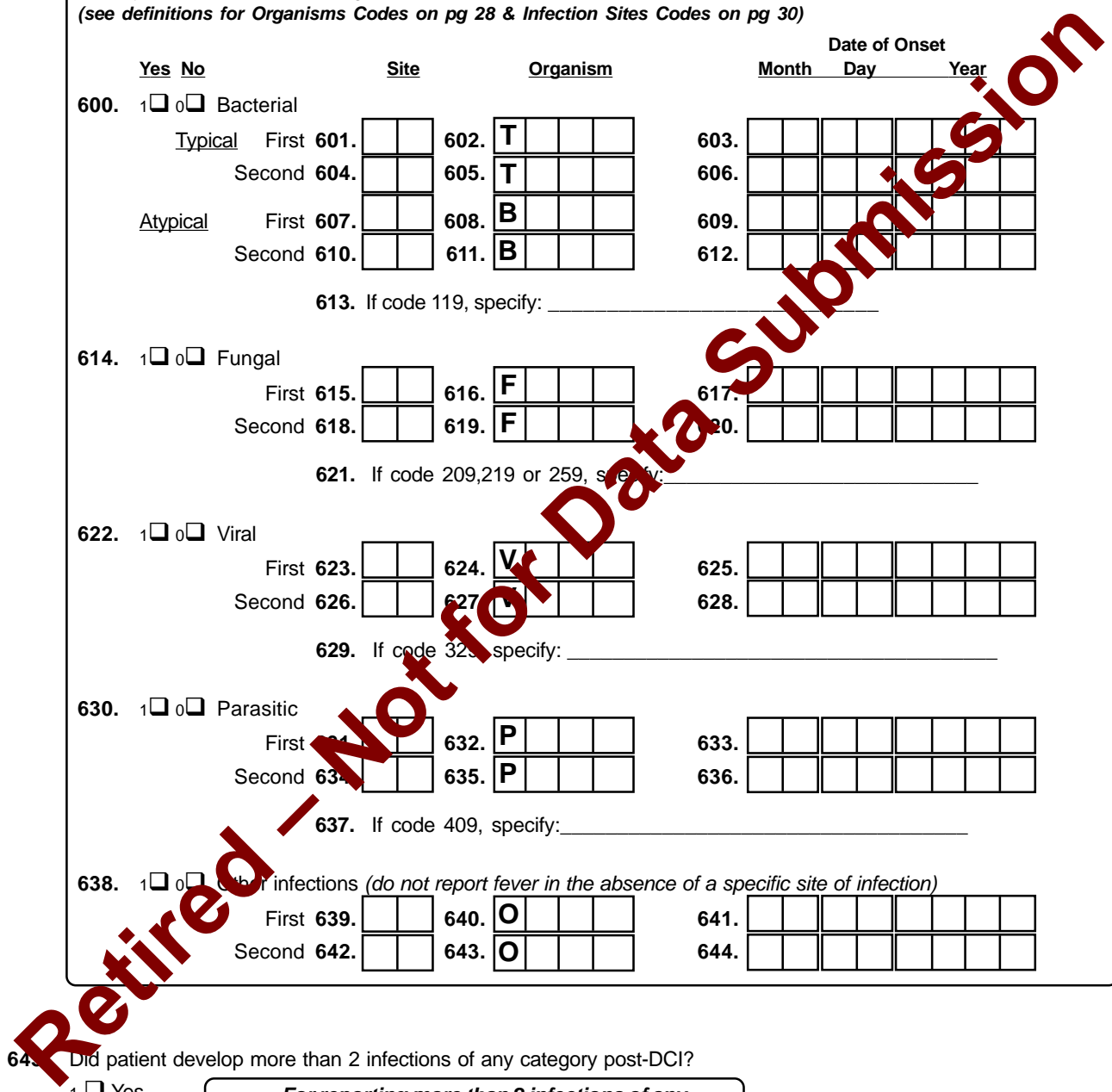
Specify site of infection and organism as First and Second, if applicable:
 (see definitions for Organisms Codes on pg 28 & Infection Sites Codes on pg 30)

Yes No	Site	Organism	Date of Onset			
			Month	Day	Year	
600. 1 <input type="checkbox"/> 0 <input type="checkbox"/> Bacterial						
Typical		First 601.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 604.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Atypical		First 607.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 610.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
602. T <input type="text"/>						
603. <input type="text"/>						
605. T <input type="text"/>						
606. <input type="text"/>						
608. B <input type="text"/>						
609. <input type="text"/>						
611. B <input type="text"/>						
612. <input type="text"/>						
613. If code 119, specify: _____						
614. 1 <input type="checkbox"/> 0 <input type="checkbox"/> Fungal						
		First 615.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 618.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		616. F <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		617. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		619. F <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		620. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
621. If code 209,219 or 259, specify: _____						
622. 1 <input type="checkbox"/> 0 <input type="checkbox"/> Viral						
		First 623.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 626.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		624. V <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		625. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		627. V <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		628. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
629. If code 323, specify: _____						
630. 1 <input type="checkbox"/> 0 <input type="checkbox"/> Parasitic						
		First 631.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 634.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		632. P <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		633. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		635. P <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		636. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
637. If code 409, specify: _____						
638. 1 <input type="checkbox"/> 0 <input type="checkbox"/> Other infections (do not report fever in the absence of a specific site of infection)						
		First 639.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second 642.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		640. O <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		641. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		643. O <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		644. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

643. Did patient develop more than 2 infections of any category post-DCI?

- 1 Yes
- 0 No

For reporting more than 2 infections of any category, copy this page and submit (do not report in Qs.638-644)



TEAM:

IUBMID:

Commonly Reported Organisms Codes

Atypical Bacteria

- 100 = Atypical bacteria, NOS
- 101 = Coxiella
- 102 = Legionella
- 103 = Leptospira
- 104 = Listeria
- 105 = Mycoplasma
- 106 = Nocardia
- 107 = Rickettsia
- 110 = Tuberculosis, NOS (AFB, acid fast bacillus, Koch bacillus)
- 111 = Typical tuberculosis (TB, Tuberculosis)
- 112 = Mycobacteria (avium, bovis, intracellulare)
- 113 = Chlamydia
- 119 = Other atypical bacteria, *specify in Q.613*
- 501 = Suspected atypical bacterial infection

Typical Bacteria

- 120 = Typical bacteria, NOS
- 121 = Acinetobacter
- 122 = Actinomyces
- 123 = Bacillus
- 124 = Bacteroides (gracilis, uniformis, vulgaris, other sp.)
- 125 = Bordetella
- 126 = Borrelia (Lyme disease)
- 127 = Branhamella or Moraxella catarrhalis (other sp.)
- 128 = Campylobacter (all sp.)
- 129 = Capnocytophaga
- 130 = Citrobacter (freundii, other sp.)
- 131 = Clostridium (all sp., except difficile)
- 132 = Clostridium difficile
- 133 = Corynebacterium (all non-diphtheria sp.)
- 134 = Enterobacter
- 135 = Enterococcus (all sp.)
- 136 = Escherichia (also E. coli)
- 137 = Flavimonas oryzihabitans
- 138 = Flavobacterium
- 139 = Fusobacterium nucleatum
- 140 = Gram Negative Diplococci, NOS
- 141 = Gram Negative Rod, NOS
- 142 = Gram Positive Cocci, NOS
- 143 = Gram Positive Rod, NOS
- 144 = Haemophilus (all sp., including influenzae)
- 145 = Helicobacter pylori
- 146 = Klebsiella
- 147 = Lactobacillus (vulgaricus, acidophilus, other sp.)
- 148 = Leptotrichia buccalis
- 149 = Leptothorax (all sp.)
- 150 = Melanobacterium
- 151 = Micrococcus, NOS
- 152 = Neisseria (gonorrhoea, meningitidis, other sp.)
- 153 = Pasteurella multocida
- 154 = Propionibacterium (acnes, avidum, granulosum, other sp.)
- 155 = Proteus
- 156 = Pseudomonas (all sp., except cepacia & maltophilia)
- 157 = Pseudomonas or Burkholderia cepacia
- 158 = Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
- 159 = Rhodococcus
- 160 = Salmonella (all sp.)
- 161 = Serratia marcescens
- 162 = Shigella
- 163 = Staphylococcus (coag. negative)

- 164 = Staphylococcus (coag. positive)
- 165 = Staphylococcus, NOS
- 166 = Stomatococcus mucilaginosus
- 167 = Streptococcus (all sp., except Enterococcus)
- 168 = Treponema (syphilis)
- 169 = Vibrio (all sp.)
- 170 = Other bacteria
- 198 = Other bacteria, *specify in Q.613*
- 502 = Suspected bacterial infection

Fungal Infections

- 200 = Candida, NOS
- 201 = Candida albicans
- 202 = Candida krusei
- 203 = Candida parapsilosis
- 204 = Candida tropicalis
- 205 = Torulopsis glabrata (a member of candida)
- 209 = Other Candida, *specify in Q.621*
- 210 = Aspergillus, NOS
- 211 = Aspergillus flavus
- 212 = Aspergillus fumigatus
- 213 = Aspergillus niger
- 219 = Other Aspergillus, *specify in Q.621*
- 220 = Cryptococcus sp.
- 230 = Fusarium sp.
- 240 = Mucormycosis (zygomycetes, rhizopus)
- 250 = Trichosporon, NOS
- 251 = Other fungus, *specify in Q.621*
- 260 = Pneumocystis (PCP)
- 303 = Suspected fungal infection

Viral Infections

- 301 = Herpes Simplex (HSV1, HSV2)
- 302 = Herpes Zoster (Chicken pox, Varicella)
- 303 = Cytomegalovirus (CMV)
- 304 = Adenovirus
- 305 = Enterovirus (Coxsackie, Echo, Polio)
- 306 = Hepatitis A (HAV)
- 307 = Hepatitis B (HBV, Australian antigen)
- 308 = Hepatitis C (HCV)
- 309 = HIV-1 (HTLV-III)
- 310 = Influenza
- 311 = Measles (Rubeola)
- 312 = Mumps
- 313 = Papovavirus
- 314 = Respiratory syncytial virus (RSV)
- 315 = Rubella (German Measles)
- 316 = Parainfluenza
- 317 = Human herpesvirus-6 (HHV-6)
- 318 = Epstein-Barr virus (EBV)
- 319 = Polyomavirus
- 320 = Rotavirus
- 321 = Rhinovirus
- 329 = Other viral, *specify in Q.629*
- 504 = Suspected viral infection

Parasite Infections

- 402 = Toxoplasma
- 403 = Giardia
- 404 = Cryptosporidium
- 409 = Other parasite (amebiasis, echinococcal cyst, trichomonas – either vaginal or gingivitis), *specify in Q.637*
- 505 = Suspected parasite infection

Other Infections

- 509 = No organism identified

Rejected - Not for Data Submission

TEAM:

IUBMID:

Pulmonary function

646. Has patient developed interstitial pneumonitis (IPn or ARDS)?

- 1 Yes
- 0 No
- 8 Unknown

Interstitial pneumonitis is characterized by hypoxia and diffuse interstitial infiltrates on chest x-ray not caused by fluid overload.

647. Has patient had prior episode(s) of IPn?

- 1 Yes
- 0 No

648. Total number of prior episodes since first HSCT:

649. Date of onset:

Month Day Year

650. Were diagnostic tests other than radiographic studies done?

- 1 Yes
- 0 No
- 8 Unknown

	Yes	No	Unknown	
651.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Bronchoalveolar lavage (BAL)
652.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Transbronchial biopsy
653.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Open/thorascopic (VATS) lung biopsy
654.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Autopsy
655.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Other

656. Specify:

657. Was an organism isolated?

- 1 Yes
- 0 No (idiopathic, or no organism isolated)

	Yes	No	Unknown	
658.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Pneumocystis carinii (PCP)
659.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Aspergillus
660.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Candida
661.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Toxoplasma
662.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Respiratory syncytial virus (RSV)
663.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Cytomegalovirus (CMV)
664.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Herpes simplex (HSV1, HSV2)
665.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Adenovirus
666.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Human herpes virus 6 (HHV-6)
667.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Other virus

668. Specify:

669. 1 0 8 Other

670. Specify:

(Report bacterial pneumonia, Q.600)

671. Did patient develop more than 1 episode of IPn during this reporting period?

- 1 Yes
- 0 No

Copy this page and complete Qs.649-670 for each subsequent episode

Retired - Not for Data Submission

TEAM:

IUBMID:

672. Did patient develop non-infectious pulmonary abnormalities other than interstitial pneumonitis/ARDS post-HSCT?

- 1 Yes
- 0 No
- 8 Unknown

673. Did patient develop bronchiolitis obliterans?

- 1 Yes
- 0 No
- 8 Unknown

674. Date of onset:

Month Day Year

675. Were diagnostic tests done?

- 1 Yes
- 0 No
- 8 Unknown

Yes No Unknown

676. 1 0 8 Bronchoalveolar lavage (BAL)

677. 1 0 8 Transbronchial biopsy

678. 1 0 8 Open/thorascopic (VATS) lung biopsy

679. 1 0 8 Autopsy

680. 1 0 8 Other

681. Specify:

682. Did patient develop pulmonary hemorrhage?

- 1 Yes
- 0 No
- 8 Unknown

683. Date of onset:

Month Day Year

684. Were diagnostic tests done?

- 1 Yes
- 0 No
- 8 Unknown

Yes No Unknown

685. 1 0 8 Bronchoalveolar lavage (BAL)

686. 1 0 8 Transbronchial biopsy

687. 1 0 8 Open/thorascopic (VATS) lung biopsy

688. 1 0 8 Autopsy

689. 1 0 8 Other

690. Specify:

691. Did patient develop other non-infectious pulmonary abnormalities?

- 1 Yes
- 0 No
- 8 Unknown

692. Specify:

Common Sites of Infection Codes

- 1 = Blood/surf coat
- 2 = Disseminated – generalized, isolated at 3 or more distinct sites
- 3 = Central Nervous System, NOS
- 4 = Brain
- 5 = Spinal cord
- 6 = Meninges and CSF
- 10 = Gastrointestinal Tract, NOS
- 11 = Lips
- 12 = Tongue, oral cavity and oropharynx
- 13 = Esophagus
- 14 = Stomach
- 15 = Gallbladder and biliary tree (not hepatitis), pancreas
- 16 = Small intestine
- 17 = Large intestine
- 18 = Feces/stool

- 19 = Peritoneum
- 20 = Liver
- 30 = Respiratory, NOS
- 31 = Upper airway and nasopharynx
- 32 = Laryngitis/larynx
- 33 = Lower respiratory tract (lung)
- 34 = Pleural cavity, pleural fluid
- 35 = Sinuses
- 40 = Genito-Urinary Tract, NOS
- 41 = Kidneys, renal pelvis, ureters and bladder
- 42 = Prostate
- 43 = Testes
- 44 = Fallopian tubes, uterus, cervix
- 45 = Vagina
- 50 = Skin, NOS
- 51 = Genital area
- 52 = Cellulitis

- 53 = Herpes Zoster
- 54 = Rash, pustules or abscesses not typical of any of the above
- 60 = Central venous catheter, NOS
- 61 = Catheter insertion or exit site
- 62 = Catheter tip
- 70 = Eyes
- 75 = Ear
- 81 = Joints
- 82 = Bone marrow
- 83 = Bone cortex (osteomyelitis)
- 84 = Muscle (excluding cardiac)
- 85 = Cardiac (endocardium, myocardium, pericardium)
- 86 = Lymph nodes
- 87 = Spleen

Strd Fig A-55

TEAM:

IUBMID:

Liver function

693. Did patient develop non-infectious liver toxicity after conditioning (excluding GVHD)?

- 1 Yes
- 0 No
- 8 Unknown

694. Date of onset:
Month Day Year

Etiology:

	Yes	No	Unknown	
695.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Veno-occlusive disease
696.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Cirrhosis
697.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Other

698. Specify:

Diagnosis in **Qs.695-698** was confirmed by:

	Yes	No	Not Done/Unknown	
699.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Clinical signs and symptoms

	Yes	No	Unknown	
700.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Jaundice
701.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Hepatomegaly
702.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Right upper quadrant pain
703.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Ascites
704.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Weight gain (>5%)
705.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	8 <input type="checkbox"/>	Other

705. Specify:

707. 1 0 8 Elevated liver enzymes (e.g., Alk Phos, ALT, AST, LDH, GGT)

708. 1 0 8 Biopsy

709. 1 0 8 Autopsy

710. 1 0 8 Ultrasonography

711. 1 0 8 Doppler

712. 1 0 8 Other

713. Specify:

714. Did patient develop any other non-infectious clinically significant organ impairment or disorder after conditioning?

- 1 Yes
- 0 No
- 8 Unknown

	Yes	No	
715.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Renal failure severe enough to warrant dialysis

716. Received dialysis? 1 Yes 0 No

717. 1 0 Posttransplant microangiopathy/thrombotic thrombocytopenic purpura (TTP) hemolytic uremic syndrome (HUS) or similar syndrome

718. 1 0 Depression

719. 1 0 Hemorrhage cystitis

720. 1 0 Seizures

721. 1 0 Avascular necrosis

722. 1 0 Cataracts

723. 1 0 Gonadal dysfunction

724. 1 0 Hypothyroidism

725. 1 0 Growth hormone deficiency/growth disturbance

726. 1 0 Myocardial infarction

727. 1 0 Other

728. Specify:

Retired - Not for Data Submission

TEAM:

IUBMID:

729. Did a new malignancy, lymphoproliferative or myeloproliferative disorder appear (not a relapse, progression or transformation of the disease for which the original transplant was performed)?

- 1 Yes
- 0 No
- 8 Unknown

730. Did more than one new malignancy develop?
1 Yes
0 No

731. Has more than 1 new malignancy been diagnosed during this reporting period?
1 Yes
0 No

For reporting more than 1 new malignancy, copy this page and complete Qs.732-746 for each

732. Date of diagnosis:
Month Day Year

733. Origin of cells: 1 Host 2 Donor 8 Unknown

Diagnosis:

	Yes	No	
734.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Clonal cytogenetic abnormality without leukemia or MDS
735.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Acute myeloid leukemia (AML, ANLL)
736.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Other leukemia

737. Specify:

738.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Myelodysplasia (MDS)/myeloproliferative (MP) disorder
739.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Lymphoma or lymphoproliferative disease

740. EBV positive: 1 Yes 0 No 8 Unknown

741.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Hodgkin disease
742.	1 <input type="checkbox"/>	0 <input type="checkbox"/>	Other cancer

Please translate into English and print neatly

743. Primary site:

744. Histologic type:

745. Behavior:
1 Benign 2 In situ 3 Malignant/Invasive 8 Unknown

746. Is a Pathology/Autopsy Report or other documentation available?
1 Yes
0 No

If Pathology/Autopsy Report or other documentation is available, attach copy with all identifiers removed except Team/IUBMID #s and birth dates, and reference Q.729

Retired - Not for Data Submission

TEAM:

IUBMID:

Survival and Functional Status

747. Was patient discharged from hospital after transplant?

1 Yes

0 No

8 Unknown

7 Not applicable (high-dose therapy and transplant/infusion given as outpatient)

748. Date first discharged from hospital after transplant:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year			

749. **Autografts only:** Total number inpatient days in first 60 days *posttransplant*:

750. **Allografts only:** Total number inpatient days in first 100 days *posttransplant*:

751. Was patient alive on the day of last contact (*Refer to pg 1 for date*)?

1 Yes

0 No

752.

***If patient is 16 years of age or older, complete the Karnofsky Scale.
If patient is younger than 16 years of age, complete the Lansky Scale.***

Go to Q.764

Karnofsky Scale (age ≥ 16 yrs) <i>Select the phrase in the Karnofsky Scale which best describes the activity status of the patient</i>	Lansky Scale (age < 16 yrs) <i>Select the phrase in the Lansky Play-Performance Scale which best describes the activity status of the patient</i>
Able to carry on normal activity; no special care is needed. 100 <input type="checkbox"/> Normal; no complaints; no evidence of disease 90 <input type="checkbox"/> Able to carry on normal activity 80 <input type="checkbox"/> Normal activity with effort	Normal range. 100 <input type="checkbox"/> Fully active 90 <input type="checkbox"/> Minor restriction in physically strenuous play 80 <input type="checkbox"/> Restricted in strenuous play, tires more easily, otherwise active
Unable to work; able to live at home, care for most personal needs; a varying amount of assistance is needed. 70 <input type="checkbox"/> Cares for self; unable to carry on normal activity or to do active work 60 <input type="checkbox"/> Requires occasional assistance but is able to care for most needs 50 <input type="checkbox"/> Requires considerable assistance and frequent medical care	Mild to moderate restriction. 70 <input type="checkbox"/> Both greater restrictions of, and less time spent in, active play 60 <input type="checkbox"/> Ambulatory up to 50% of time, limited active play with assistance/supervision 50 <input type="checkbox"/> Considerable assistance required for any active play; fully able to engage in quiet play
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly. 40 <input type="checkbox"/> Disabled; requires special care and assistance 30 <input type="checkbox"/> Severely disabled; hospitalization indicated, although death not imminent 20 <input type="checkbox"/> Very sick; hospitalization necessary 10 <input type="checkbox"/> Moribund; fatal process progressing rapidly	Moderate to severe restriction. 40 <input type="checkbox"/> Able to initiate quiet activities 30 <input type="checkbox"/> Needs considerable assistance for quiet activity 20 <input type="checkbox"/> Limited to very passive activity initiated by others (i.e., TV) 10 <input type="checkbox"/> Completely disabled, not even passive play

Strd Fig A-57

TEAM:

IUBMID:

Subsequent HSCT*

** Complete this section if a subsequent HSCT was received (see Q.317). Answers on pgs 16-32 of this report should reflect clinical status immediately prior to start of conditioning for subsequent HSCT.*

A separate Day 100 Report Form must be submitted unless the subsequent HSCT is autologous for treatment of graft failure

753. Date of subsequent HSCT:
Month Day Year

Date will be later than Q.4 unless HSCT is autologous for treatment for graft failure

754. Reason for subsequent HSCT (check only one):

- 1 No engraftment
- 2 Partial engraftment
- 3 Late graft failure
- 4 Persistent malignancy
- 5 Relapse
- 6 Planned second HSCT, per protocol
- 8 Secondary/new malignancy
- 90 Other reason

Autologous re-infusions for these reasons do not require separate Report Form completion

Complete new malignancy Qs.729-746

755. Specify: _____

756. Type of graft (check only one):

- 1 Allogeneic, related
- 2 Allogeneic, unrelated
- 3 Autologous

757. Donor (check only one):

- 1 Same donor
- 2 Different donor
- 3 Not applicable, initial transplant was autologous

758. Was the subsequent HSCT performed at a different institution?

- 1 Yes
- 0 No

759. Specify:
Name: _____
City: _____ State: _____
Country: _____

Retired - Not for Data Submission

TEAM:

IUBMID:

Subsequent DCI*

** Complete this section if a subsequent DCI was received >14 days from the HSCT for this Report Form (see Q.318).
Answers on pgs 16-33 of this report should reflect clinical status immediately prior to subsequent DCI.*

A separate Day 100 DCI Report Form must be submitted

760. Date first subsequent DCI given:
Month Day Year

*Date will be later than Q.4
(last contact date)*

761. Was infusion performed at a different institution?

- 1 Yes
- 0 No

762. Specify:
Name: _____
City: _____ State: _____
Country: _____

763. If patient received a DCI >14 days post-HSCT, was therapy given to treat the patient's disease between this HSCT and the next reportable DCI?

- 1 Yes
- 0 No

Complete a Disease Supplement and submit with the next DCI Report Form

Retired – Not for Data Submission

TEAM:

IUBMID:

Death Information

764. Date of death:
Month Day Year

Cause(s) of death:

Enter appropriate cause of death (see Cause of Death Codes):

765. Primary: — If code 29, 39, 88, 89, 109, 129 or 900, specify:

Contributing or secondary causes:

766. — If code 29, 39, 88, 89, 109, 129 or 900, specify:

767. — If code 29, 39, 88, 89, 109, 129 or 900, specify:

768. — If code 29, 39, 88, 89, 109, 129 or 900, specify:

769. — If code 29, 39, 88, 89, 109, 129 or 900, specify:

770. — If code 29, 39, 88, 89, 109, 129 or 900, specify:

771. Was cause of death confirmed by autopsy?

- 1 Yes
- 0 No
- 8 Unknown
- 6 Pending

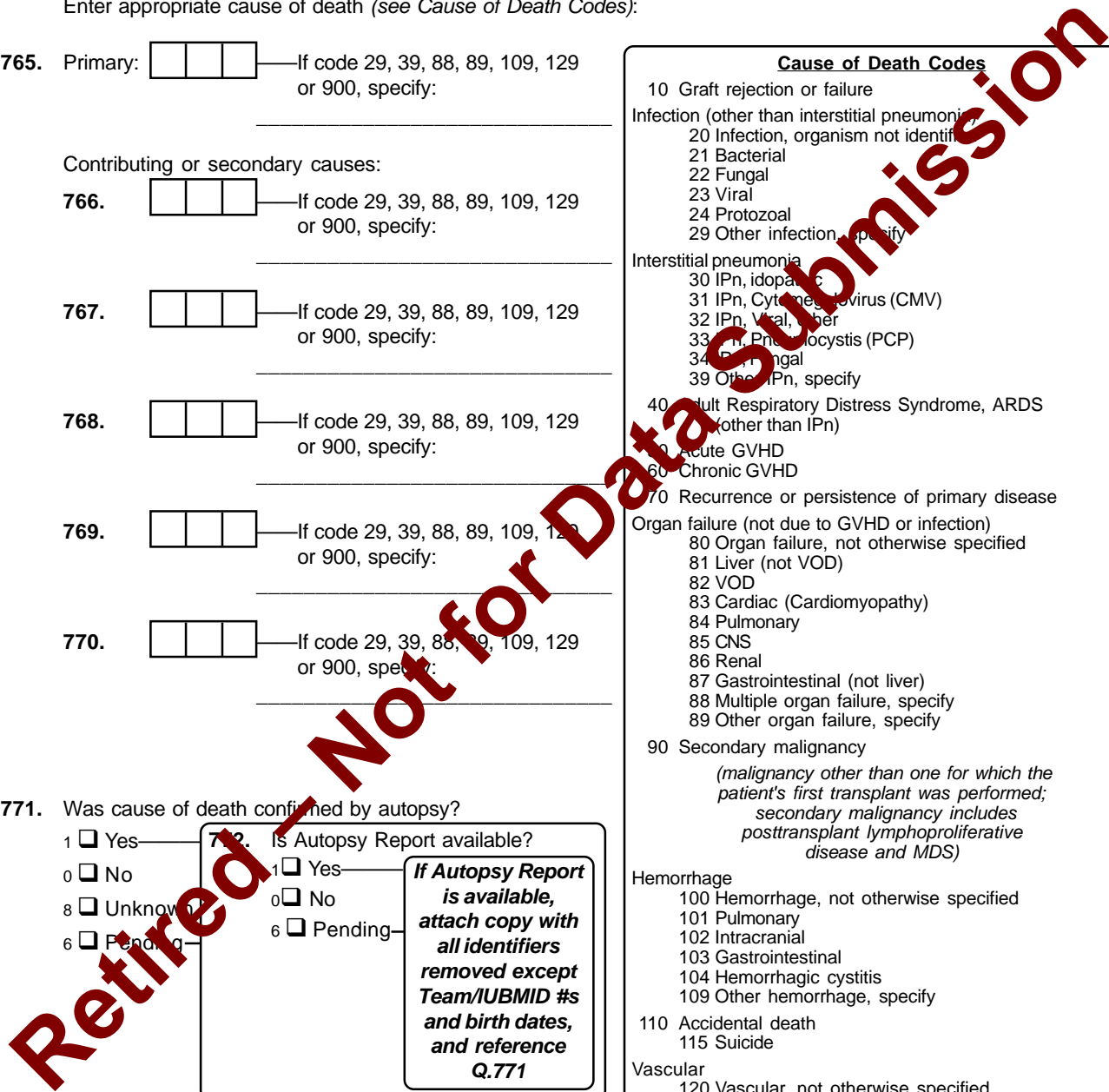
772. Is Autopsy Report available?

- 1 Yes
- 0 No
- 6 Pending

If Autopsy Report is available, attach copy with all identifiers removed except Team/IUBMID #s and birth dates, and reference Q.771

Cause of Death Codes

- 10 Graft rejection or failure
- Infection (other than interstitial pneumonia)
 - 20 Infection, organism not identified
 - 21 Bacterial
 - 22 Fungal
 - 23 Viral
 - 24 Protozoal
 - 29 Other infection, specify
- Interstitial pneumonia
 - 30 IPn, idiopathic
 - 31 IPn, Cytomegalovirus (CMV)
 - 32 IPn, Viral, other
 - 33 IPn, Pneumocystis (PCP)
 - 34 IPn, Fungal
 - 39 Other IPn, specify
- 40 Adult Respiratory Distress Syndrome, ARDS (other than IPn)
- 50 Acute GVHD
- 60 Chronic GVHD
- 70 Recurrence or persistence of primary disease
- Organ failure (not due to GVHD or infection)
 - 80 Organ failure, not otherwise specified
 - 81 Liver (not VOD)
 - 82 VOD
 - 83 Cardiac (Cardiomyopathy)
 - 84 Pulmonary
 - 85 CNS
 - 86 Renal
 - 87 Gastrointestinal (not liver)
 - 88 Multiple organ failure, specify
 - 89 Other organ failure, specify
- 90 Secondary malignancy
(malignancy other than one for which the patient's first transplant was performed; secondary malignancy includes posttransplant lymphoproliferative disease and MDS)
- Hemorrhage
 - 100 Hemorrhage, not otherwise specified
 - 101 Pulmonary
 - 102 Intracranial
 - 103 Gastrointestinal
 - 104 Hemorrhagic cystitis
 - 109 Other hemorrhage, specify
- 110 Accidental death
- 115 Suicide
- Vascular
 - 120 Vascular, not otherwise specified
 - 121 Thromboembolic
 - 122 Disseminated intravascular coagulation (DIC)
 - 123 Thrombotic thrombocytopenic purpura (HUS/TTP)
 - 129 Other vascular, specify
- 130 In utero death (for in utero transplants)
- 140 Prior malignancy
(malignancy existing before disease for which transplant performed as reported in Q.17)
- 900 Other, specify



TEAM:

IUBMID:

Confidential/Socioeconomic Information*

** Complete for the first transplant only*

773. Patient's state of residence (US only):

773.² Patient's zip code (US only):

774. Country of residence (check only one):

- | | | | |
|--|---------------------------------------|--|---|
| 1 <input type="checkbox"/> United States | 11 <input type="checkbox"/> Denmark | 22 <input type="checkbox"/> Japan | 33 <input type="checkbox"/> South Africa |
| 2 <input type="checkbox"/> Argentina | 44 <input type="checkbox"/> Egypt | 23 <input type="checkbox"/> Jordan | 34 <input type="checkbox"/> Spain |
| 3 <input type="checkbox"/> Austria | 12 <input type="checkbox"/> England | 24 <input type="checkbox"/> Korea | 35 <input type="checkbox"/> Sweden |
| 4 <input type="checkbox"/> Australia | 13 <input type="checkbox"/> Finland | 25 <input type="checkbox"/> Malaysia | 36 <input type="checkbox"/> Switzerland |
| 5 <input type="checkbox"/> Belgium | 14 <input type="checkbox"/> France | 43 <input type="checkbox"/> Mexico | 37 <input type="checkbox"/> Taiwan |
| 41 <input type="checkbox"/> Bosnia | 15 <input type="checkbox"/> Germany | 26 <input type="checkbox"/> Netherlands | 45 <input type="checkbox"/> Turkey |
| 6 <input type="checkbox"/> Brazil | 49 <input type="checkbox"/> Greece | 27 <input type="checkbox"/> New Zealand | 47 <input type="checkbox"/> Uruguay |
| 7 <input type="checkbox"/> Canada | 46 <input type="checkbox"/> Hong Kong | 28 <input type="checkbox"/> Norway | 39 <input type="checkbox"/> Venezuela |
| 8 <input type="checkbox"/> Chile | 17 <input type="checkbox"/> Hungary | 50 <input type="checkbox"/> Peru | 44 <input type="checkbox"/> Wales |
| 9 <input type="checkbox"/> China | 18 <input type="checkbox"/> India | 29 <input type="checkbox"/> Poland | 53 <input type="checkbox"/> Yugoslavia |
| 52 <input type="checkbox"/> Costa Rica | 48 <input type="checkbox"/> Iran | 30 <input type="checkbox"/> Portugal | 88 <input type="checkbox"/> Unknown/Unspecified |
| 51 <input type="checkbox"/> Croatia | 19 <input type="checkbox"/> Ireland | 38 <input type="checkbox"/> Russia | 90 <input type="checkbox"/> Other Country, specify: _____ |
| 10 <input type="checkbox"/> Cuba | 20 <input type="checkbox"/> Israel | 31 <input type="checkbox"/> Saudi Arabia | |
| 42 <input type="checkbox"/> Czech Republic | 21 <input type="checkbox"/> Italy | 32 <input type="checkbox"/> Scotland | |

775. Is Patient ≥ 18 years old?

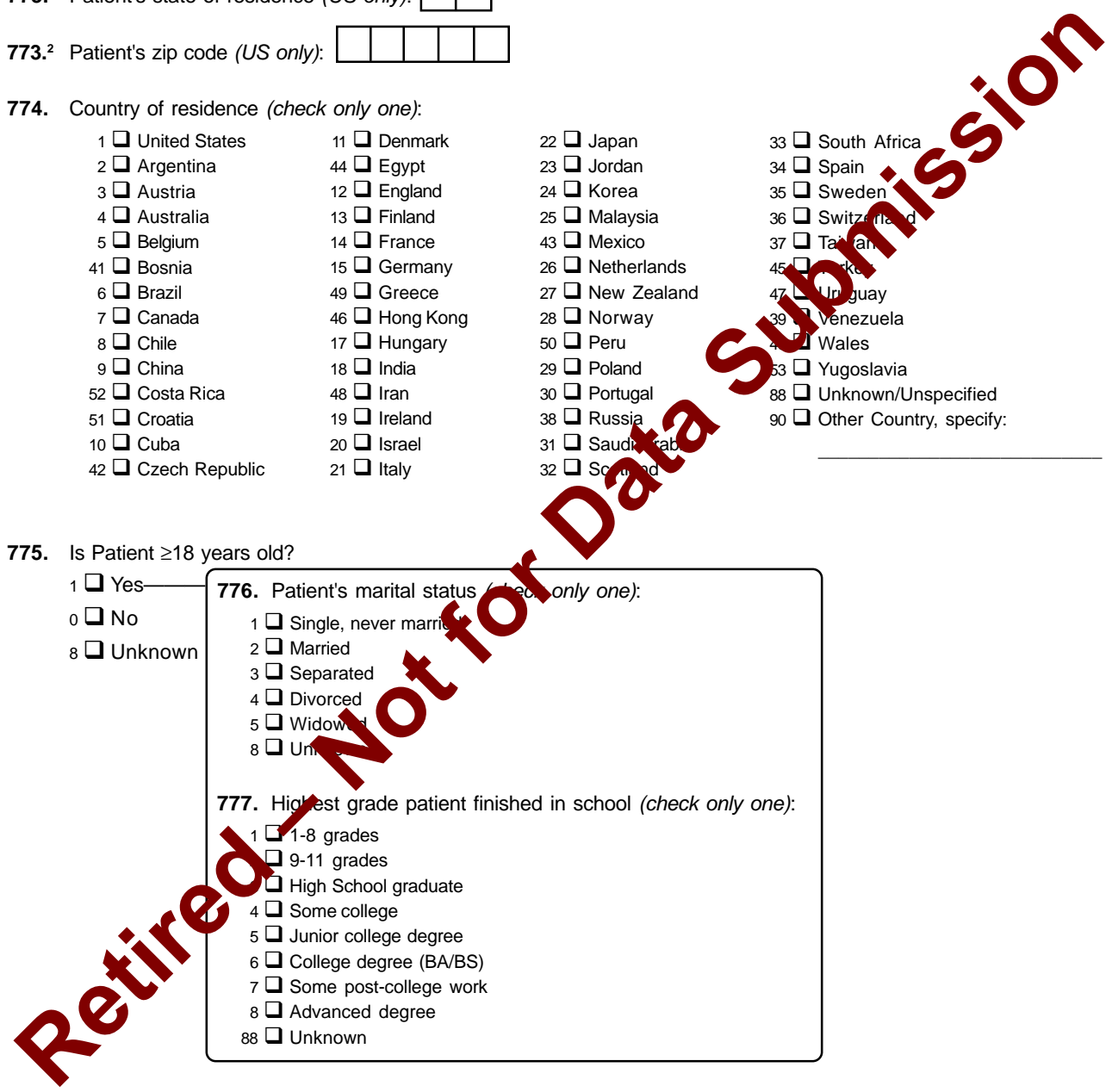
- 1 Yes
0 No
8 Unknown

776. Patient's marital status (check only one):

1 Single, never married
2 Married
3 Separated
4 Divorced
5 Widowed
8 Unknown

777. Highest grade patient finished in school (check only one):

1 1-8 grades
 9-11 grades
 High School graduate
4 Some college
5 Junior college degree
6 College degree (BA/BS)
7 Some post-college work
8 Advanced degree
88 Unknown



TEAM:

IUBMID:

Type of health insurance:

Yes No Unknown

- 778. 1 0 8 No insurance
- 779. 1 0 8 Medicaid
- 780. 1 0 8 Medicare (US)
- 781. 1 0 8 Disability insurance
- 782. 1 0 8 HMO
- 783. 1 0 8 Individual health insurance
- 784. 1 0 8 Group health insurance
- 785. 1 0 8 National health insurance (non-US)
- 786. 1 0 8 V.A./Military
- 787. 1 0 8 Other, specify: _____

788. **US patients only:** Type of fee reimbursement (*check only one*):

- 1 Fee for service
- 2 Capitation
- 7 Other, specify: _____
- 8 Unknown

789. Which category best describes patient's occupation (*check only one*)?

If not currently employed, which best describes patient's last job.

- 1 Professional, Technical & Related Occupations (teacher/professor, nurse, lawyer, physician or engineer)
- 2 Manager, Administrator or Proprietor (sales manager, real estate agent or postmaster)
- 3 Clerical & Related Occupations (secretary, clerk or mail carrier)
- 4 Sales Occupation (salesperson, demonstrator, agent or broker)
- 5 Service Occupation (police, cook or tradesman)
- 6 Skilled crafts & Related Occupations (carpenter, repairer or telephone line worker)
- 7 Equipment or Vehicle Operator & Related Occupations (driver, railroad brakeman or sewer worker)
- 8 Laborer (helper, longshoreman or warehouse worker)
- 9 Farmer (owner, manager, operator or tenant)
- 10 Member of the military
- 11 Homemaker
- 90 Other, specify description: _____
- 88 Unknown

790. **US patients only:** What is patient's yearly income, earned by all family members living in household before taxes (*check only one*)?

- 1 Less than \$5,000
- 2 \$5,000-9,999
- 3 \$10,000-19,999
- 4 \$20,000-29,999
- 5 \$30,000-39,999
- 6 \$40,000-49,999
- 7 \$50,000-59,999
- 8 \$60,000-79,999
- 9 \$80,000 and over
- 88 Unknown

TEAM: [][][][]

IUBMID: [][][][][][]

Log of Appended Documents

791. Number of attached documents: [][] Attach as many documents as indicated throughout this form and describe below. Remove all identifiers except Team/IUBMID #s and birth dates. Copy this page for each additional ≤5 documents attached.

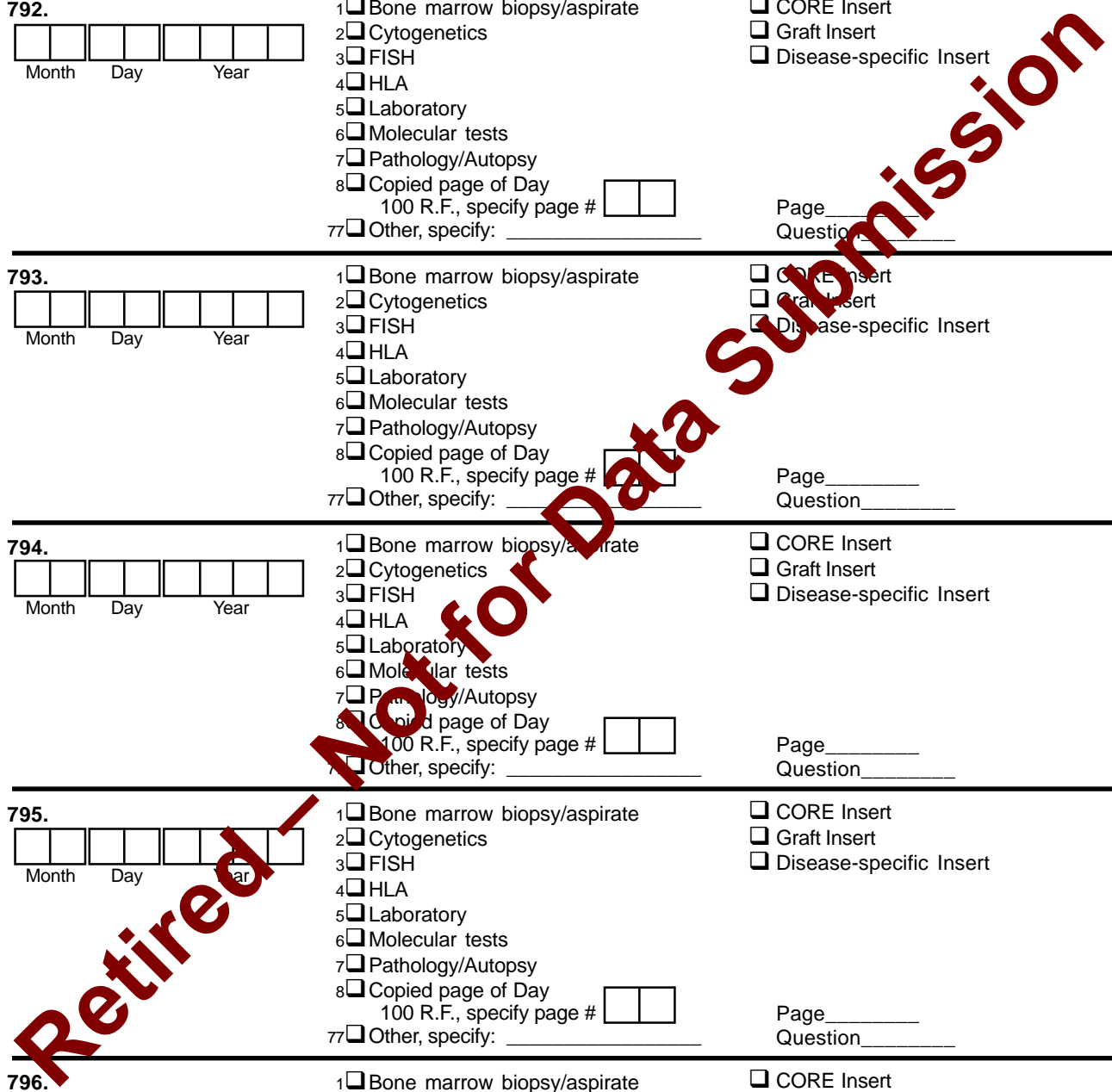
Date of Document	Type of Document	Document Referenced To
792. [][] [][] [][][][] Month Day Year	<input type="checkbox"/> 1 Bone marrow biopsy/aspirate <input type="checkbox"/> 2 Cytogenetics <input type="checkbox"/> 3 FISH <input type="checkbox"/> 4 HLA <input type="checkbox"/> 5 Laboratory <input type="checkbox"/> 6 Molecular tests <input type="checkbox"/> 7 Pathology/Autopsy <input type="checkbox"/> 8 Copied page of Day [][] 100 R.F., specify page # [][] <input type="checkbox"/> 77 Other, specify: _____	<input type="checkbox"/> CORE Insert <input type="checkbox"/> Graft Insert <input type="checkbox"/> Disease-specific Insert Page _____ Question _____

793. [][] [][] [][][][] Month Day Year	<input type="checkbox"/> 1 Bone marrow biopsy/aspirate <input type="checkbox"/> 2 Cytogenetics <input type="checkbox"/> 3 FISH <input type="checkbox"/> 4 HLA <input type="checkbox"/> 5 Laboratory <input type="checkbox"/> 6 Molecular tests <input type="checkbox"/> 7 Pathology/Autopsy <input type="checkbox"/> 8 Copied page of Day [][] 100 R.F., specify page # [][] <input type="checkbox"/> 77 Other, specify: _____	<input type="checkbox"/> CORE Insert <input type="checkbox"/> Graft Insert <input type="checkbox"/> Disease-specific Insert Page _____ Question _____
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794. [][] [][] [][][][] Month Day Year	<input type="checkbox"/> 1 Bone marrow biopsy/aspirate <input type="checkbox"/> 2 Cytogenetics <input type="checkbox"/> 3 FISH <input type="checkbox"/> 4 HLA <input type="checkbox"/> 5 Laboratory <input type="checkbox"/> 6 Molecular tests <input type="checkbox"/> 7 Pathology/Autopsy <input type="checkbox"/> 8 Copied page of Day [][] 100 R.F., specify page # [][] <input type="checkbox"/> 77 Other, specify: _____	<input type="checkbox"/> CORE Insert <input type="checkbox"/> Graft Insert <input type="checkbox"/> Disease-specific Insert Page _____ Question _____
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795. [][] [][] [][][][] Month Day Year	<input type="checkbox"/> 1 Bone marrow biopsy/aspirate <input type="checkbox"/> 2 Cytogenetics <input type="checkbox"/> 3 FISH <input type="checkbox"/> 4 HLA <input type="checkbox"/> 5 Laboratory <input type="checkbox"/> 6 Molecular tests <input type="checkbox"/> 7 Pathology/Autopsy <input type="checkbox"/> 8 Copied page of Day [][] 100 R.F., specify page # [][] <input type="checkbox"/> 77 Other, specify: _____	<input type="checkbox"/> CORE Insert <input type="checkbox"/> Graft Insert <input type="checkbox"/> Disease-specific Insert Page _____ Question _____
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796. [][] [][] [][][][] Month Day Year	<input type="checkbox"/> 1 Bone marrow biopsy/aspirate <input type="checkbox"/> 2 Cytogenetics <input type="checkbox"/> 3 FISH <input type="checkbox"/> 4 HLA <input type="checkbox"/> 5 Laboratory <input type="checkbox"/> 6 Molecular tests <input type="checkbox"/> 7 Pathology/Autopsy <input type="checkbox"/> 8 Copied page of Day [][] 100 R.F., specify page # [][] <input type="checkbox"/> 77 Other, specify: _____	<input type="checkbox"/> CORE Insert <input type="checkbox"/> Graft Insert <input type="checkbox"/> Disease-specific Insert Page _____ Question _____
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Institutional Information

TEAM:

IUBMID:
(Institutional Unique Blood or Marrow Transplant Identification Number)

Date of transplant for which this form is being completed: / /
Month Day Year

FOR REGISTRY USE ONLY:

I.D. - -

Date received: _____

Log: _____ PC: _____

Registry (circle one): IBMTR ABMTR

Date of report: / /
Month Day Year

i. Signed: _____ / _____
Person completing this form / Print name

ii. Name of doctor for correspondence: _____
 Institution: _____
 Address: _____

iii. Telephone: Ext.:
 iv. Fax:

v. Make reimbursement check payable to: _____
Payment for data forms is contingent on the availability of funds that have been obtained from sources external to the Medical College of Wisconsin for purposes of these payments.

vi. Patient or authorized family member/guardian is aware of, and has consented to, the fact that this case is being entered into the Registry database: _____ (physician's initials)

vii. Determining cut-off for all parts of this report:
 A complete report of transplant consists of the following three parts (*all 3 parts should have the same date of report and date of transplant*):

- 1 A (white) Day 100 CORE Insert
- 2 An appropriate (blue or pink) graft-specific insert (Insert ALLOBM, ALLOPB, ALLOCB, AUTOPB or AUTOBM)
- 3 An appropriate (ivory) disease-specific insert



viii. Was a subsequent reportable transplant or infusion, as defined on **pgs 15 & 16** performed?

1 Yes
 0 No

ix. Was conditioning given for subsequent transplant?
 1 Yes — **Cut off for this Report Form is one day prior to conditioning start date**
 0 No — **Cut off for this Report Form is one day prior to the subsequent infusion**

x. Enter date 100 days from transplant (e.g., Month, Day, Year):

Enter this date on pg 1 of the 002-CORE Insert.
NOTE: Report information in the CORE Insert and Disease-specific Insert only up to last contact date. Later information should be reported in a Follow-up Report Form or Report Form for a subsequent transplant when it is due.

xi. Was patient alive on Day 100 for this Report Form?
 1 Yes — **The last contact date for all parts of this Report Form should be up to Day 100 or slightly beyond if patient was not actually seen on Day 100**
 0 No — **The last contact date for all parts of this Report Form should be the date of death – No separate Follow-up Report Form is required**

