Follow-up Core Insert

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

1. Date of HSCT/DCI 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*

2. Date of report: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Series 2002 Reporting Forms

IBMTR ABMTR

Statistical Center
Medical College of Wisconsin
P.O. Box 26509, 8701 Watertown Plank Road
Milwaukee, WI 53226
▪ *Telephone: 414-456-8325* ▪ *Fax: 414-456-6530*
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Follow-up Information

*For living patients, submit follow-up data every 12 months from date of transplant. If more than 1 years have elapsed without submitting a Follow-up Report form, it is only necesary to complete one Follow-up ending with the most recent patient contact. If patient died since last report, indicate findings present at time of death. For patients lost to follow-up since last report, submit last known information. If another infusion was done since last report, see sections of **Qs.18** & **19** of this report to determine if a separate Day 100 Report is required.*

3. Patient date of birth: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

4. Date of last actual contact (LCD) with patient to determine medical status for this report *(See **Q.viii** on **pg 22** for help determining cut-off contact date for this report)*: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Survival and Functional Status

5. Was patient alive on the day of last contact? 1 ❑ Yes 0 ❑ No——Go to ***Q.18***

6. *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.

Karnofsky Scale (age ≥16 yrs)

Select the phrase in the Karnofsky Scale which best describes the activity status of the patient

Able to carry on normal activity; no special care is needed.
- 100 ❑ Normal; no complaints; no evidence of disease
- 90 ❑ Able to carry on normal activity
- 80 ❑ Normal activity with effort

Unable to work; able to live at home, care for most personal needs; a varying amount of assistance is needed.
- 70 ❑ Cares for self; unable to carry on normal activity or to do active work
- 60 ❑ Requires occasional assistance but is able to care for most needs
- 50 ❑ Requires considerable assistance and frequent medical care

Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.
- 40 ❑ Disabled; requires special care and assistance
- 30 ❑ Severely disabled; hospitalization indicated, although death not imminent
- 20 ❑ Very sick; hospitalization necessary
- 10 ❑ Moribund; fatal process progressing rapidly

Lansky Scale (age <16 yrs)

Select the phrase in the Lansky Play-Performance Scale which best describes the activity status of the patient

Normal range.
- 100 ❑ Fully active
- 90 ❑ Minor restruction in physically strenuous play
- 80 ❑ Restricted in strenuous play, tires more easily, otherwise active

Mild to moderate restriction.
- 70 ❑ Both greater restrictions of, and less time spent in, active play
- 60 ❑ Ambulatory up to 50% of time, limited active play with assistance/supervision
- 50 ❑ Considerable assistance required for any active play; fully able to engage in quiet play

Moderate to severe restriction.
- 40 ❑ Able to initiate quiet activities
- 30 ❑ Needs considerable assistance for quiet activity
- 20 ❑ Limited to very passive activity initiated by others (i.e., TV)
- 10 ❑ Completely disabled, not even passive play

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

7. Does patient (age ≥6 years) currently attend school *(if dead, skip to **Q.18**)*?

1 ❑ Yes
- **8.** Specify patient student status:
  1 ❑ Part-time 2 ❑ Full-time 8 ❑ Unknown, whether part-time or full-time
- **9.** Date returned to school: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown ❑ Reported previously

0 ❑ No

7 ❑ <6 years — Go to ***Q.18***

10. Has patient resumed all household activities?

1 ❑ Yes
- **11.** Date activities resumed: ☐☐ Month ☐☐☐☐ Year ❑ Date unknown ❑ Reported previously

0 ❑ No

8 ❑ Unknown

12. Was patient employed outside the home prior to current illness?

1 ❑ Yes
- **13.** Has patient returned to work?
  1 ❑ Yes
  - **14.** Date returned to work: ☐☐ Month ☐☐☐☐ Year ❑ Date unknown ❑ Reported previously
  0 ❑ No
  - **15.** Is patient able to work but not employed? 1 ❑ Yes 0 ❑ No
  8 ❑ Unknown

0 ❑ No
- **16.** Is patient now employed?
  1 ❑ Yes
  - **17.** Date began work: ☐☐ Month ☐☐☐☐ Year ❑ Date unknown ❑ Reported previously
  0 ❑ No
  8 ❑ Unknown

7 ❑ <18 years

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 Thorascopic Surgery
VOD	=	Veno-occlusive Disease

TEAM: | | | | | IUBMID: | | | | | | |

Post-HSCT/DCI Information

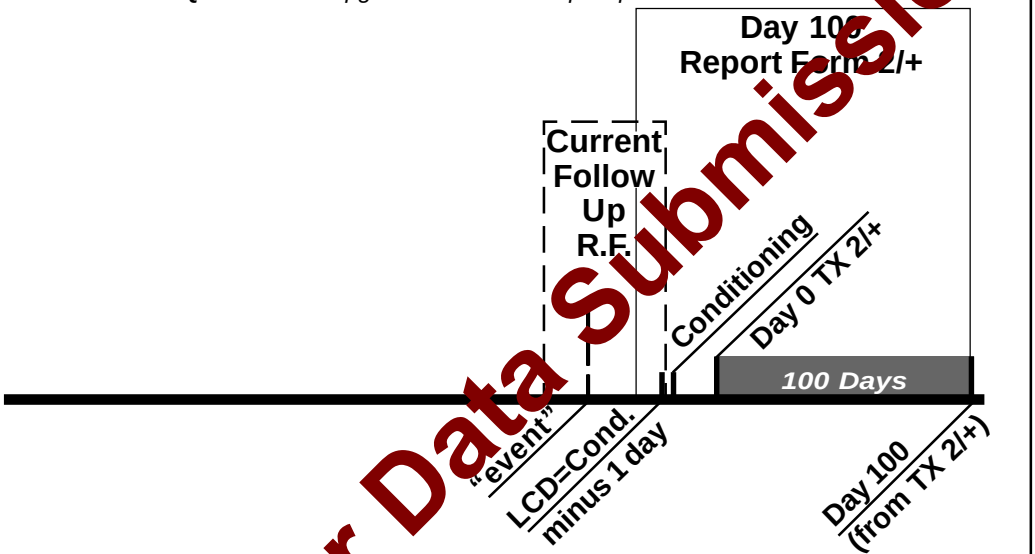
18. Did patient receive a subsequent HSCT >100 days after the previous HSCT/DCI?

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

>100 days between HSCT/DCI Infusions

Complete Follow-up Report Form to cover events occurring >100 days after HSCT/DCI up to conditioning for HSCT minus 1 day.
*Be sure to answer **Qs.341-347** on pg 18 of this Follow-up Report Form.*



Stnd Fig A-62

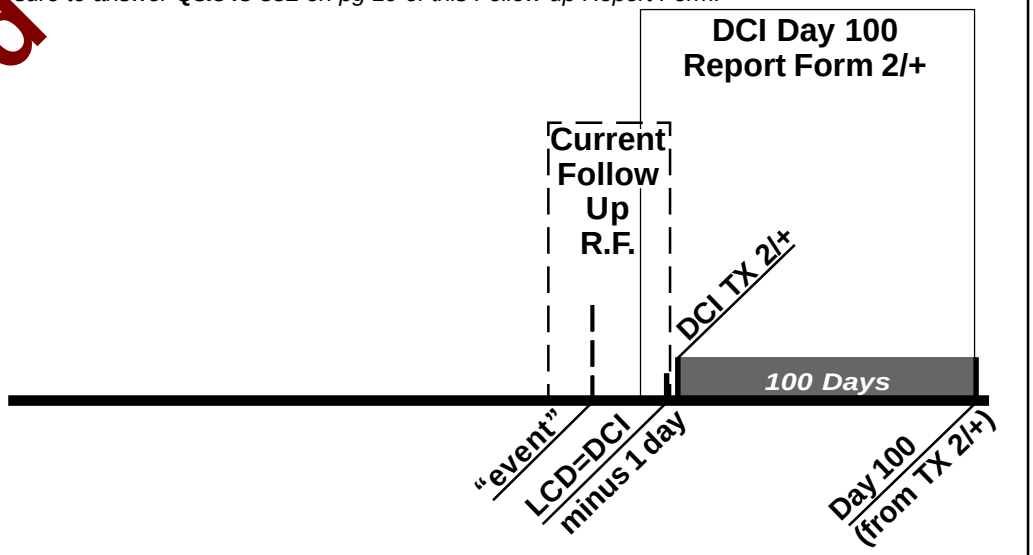
19. Has patient received (from the original donor) a subsequent DCI that requires reporting on a separate DCI form based on the DCI Calculation Timeline *(see pg 4)*?

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

>100 days between HSCT/DCI Infusions

Complete Follow-up Report Form to cover events >100 days after HSCT/DCI and up to first infusion of subsequent DCI minus 1 day.
*Be sure to answer **Qs.348-351** on pg 19 of this Follow-up Report Form.*



Stnd Fig A-63

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Granulopoiesis*

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

20. Did patient achieve an initial hematopoietic recovery (ANC ≥500/mm³ for 3 consecutive lab values*) since last report?

1 ❑ Yes
- **21.** Date ANC ≥500/mm³ *(first of 3 consecutive lab values*)*: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown

2 ❑ No, patient's initial hematopoietic recovery was recorded on a previous report

3 ❑ No, patient has never achieved an ANC ≥500/mm³ for 3 consecutive lab values* and there is no evidence of recurrent disease

4 ❑ No, patient has never achieved an ANC ≥500/mm³ for 3 consecutive lab values* and there was documented persistent malignant disease posttransplant

22. Following initial hematopoietic recovery (ANC ≥500/mm³ for 3 consecutive lab values*) did the patient experience a subsequent decline in ANC to <500/mm³ for greater than 3 consecutive lab values* since last report?

1 ❑ Yes
- **23.** Date of decline in ANC to <500/mm³ for greater than 3 consecutive lab values* *(first of 3 consecutive lab values* that ANC declined)*: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown
- **24.** Did patient recover and maintain ANC >500/mm³ following the decline?

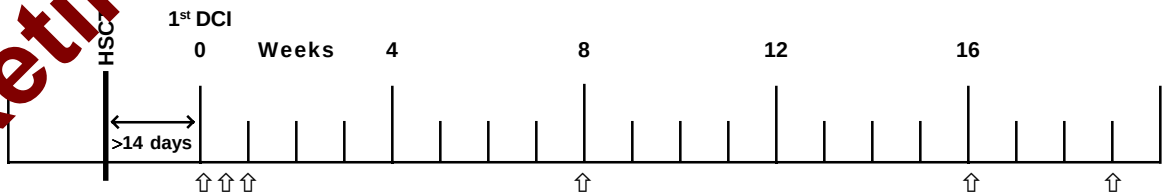
  1 ❑ Yes
  - **25.** Date of ANC recovery: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown
  - **26.** WBC: ☐☐☐☐☐☐.☐ ❑ x10⁹/L ❑ x10⁶/L
  - **27.** Neutrophils: ☐☐ %

  0 ❑ No

0 ❑ No

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:



These 3 DCI would be reported on one DCI Report Form.

This DCI would be reported on a separate DCI Report Form.

These 2 DCI would be reported together on a separate DCI Report Form.

Stnd Fig A-53

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.

28. Did recipient achieve an initial platelet count of ≥20 x 10^9/L since last report?

1 ❑ Yes
- **29.** Date platelets ≥20 x 10^9/L: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown

2 ❑ No, recipient achieved a platelet count of ≥20 x 10^9/L but <50 x 10^9/L prior to last report
- **30.** Was a platelet count of ≥50 x 10^9/L achieved?
  - 1 ❑ Yes
  - 0 ❑ No
  - 8 ❑ Unknown
  - **31.** Date platelets ≥50 x 10^9/L: ☐☐ Month ☐☐ Day ☐☐☐☐ Year ❑ Date unknown

3 ❑ No, recipient achieved a platelet count of ≥50 x 10^9/L prior to last report

0 ❑ No, recipient never achieved a platelet count of ≥20 x 10^9/L

Current Hematologic Findings

CBC results: **32.** Date of most recent test: Month ☐☐ Day ☐☐ Year ☐☐☐☐ — Not Tested ❑

		Specify Units	Not Tested
33.	WBC: ☐☐☐☐☐.☐	1❑ x 10^9/L (x10^3/mm^3) 2❑ x 10^6/L	❑
34.	Neutrophils: ☐☐ %		❑
35.	Lymphocytes: ☐☐ %		❑
36.	Hemoglobin: ☐☐☐☐.☐☐	1❑g/dl 2❑g/L 3❑mmol/L ❑Transfused RBC <30 days from ***Q.32***	❑
37.	Hematocrit: ☐☐ %	❑Transfused RBC <30 days from ***Q.32***	❑
38.	Platelets: ☐☐☐☐☐☐☐	1❑ x10^9/L (x10^3/mm^3) 2❑ x10^6/L ❑Transfused platelets <7 days from ***Q.32***	❑

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Chimerism Studies

Allo only:

39. Were chimerism studies performed (Disappearance of an abnormality associated with the patient's disease [e.g., Philadephia chromosome] indicates remission of disease, but does not by itself support chimerism)?

1 ❑ Yes ——— *Provide information below*

0 ❑ No

8 ❑ Unknown

	Date (month day year)	Cell Method (See valid list below)	Cell Type (See valid list below)	Number of Cells Examined (total cells)	Number of Donor Cells	Number of Host Cells	Percent of Donor Cells Quantity	Percent of Donor Cells *Non-Qty	Percent of Host Cells Quantity	Percent of Host Cells *Non-Qty
40.										
41.										
42.										
43.										
44.										
45.										
46.										
47.										
48.										
49.										
50.										
51.										

** If performed by non-quantitative method, indicate the presence of donor or host cells by (1) in Non-Qty Column*

Valid Method Codes

1 = Standard Cytogenetics
2 = Fluorescent in situ Hybridization (FISH)
3 = Restriction Fragment-length polymorphisms (RFLP)
5 = HLA typing
6 = VNTR (variable nucleotide tandem repeats) or STR (short tandem repeats)
8 = ABO Blood Group change
90 = Other, specify: _____

Note: If PCR was done, determine method used for chimerism study, e.g., RFLP, VNTR, STR, etc)

Valid Cell Types

1 = Bone Marrow (BM)
2 = Peripheral Blood Mononuclear Cells (PBMC)
3 = T-cells
4 = B-cells
5 = Red Cells
6 = Monocytes
7 = Neutrophils
90 = Other, specify: _____

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Acute Graft-vs-Host Disease (GVHD)

52. Was acute GVHD still present at time of last report?

1 ❑ Yes
0 ❑ No

53. Did acute GVHD develop since date of last report?

1 ❑ Yes
0 ❑ No — *Go to* ***Q.113***
8 ❑ Unknown — *Go to* ***Q.113***

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

55. What was diagnosis based on?

1❑ Histologic evidence
2❑ Clinical evidence
3❑ Both
8❑ Unknown

56. Date of onset: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year) ❑ Previously reported

57. Is acute GVHD still present at last contact date for this Follow-up Report Form?

1❑ Yes
0❑ No
2❑ Progressed to chronic GVHD
8❑ Unknown

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

58. Skin:

Stage 0	Stage 1	Stage 2	Stage 3	Stage 4
0❑ No skin GVHD 1❑ No rash	2❑ Maculopapular rash,<25% of body surface	3❑ Maculopapular rash, 25-50% of body surface	4❑ Generalized erythroderma	5❑ Generalized erythroderma with bullae formation and desquamation

59. Intestinal tract (use ml/day for adult patients and ml/m²/day for pediatric patients):

0❑ No gut GVHD 1❑ Diarrhea <500 ml/day or <280 ml/m²/day	2❑ Diarrhea >500 but ≤1000 ml/day or 280-555 ml/m²/day 6❑ Persistent nausea and vomiting	3❑ Diarrhea >1000 but ≤1500 ml/day or 556-833 ml/m²/day	4❑ Diarrhea >1500 ml/day or >833 ml/m²/day	5❑ Severe abdominal pain, with or without ileus

60. Liver:

0❑ Bilirubin evaluated, not attributed to GVHD

1❑ Bilirubin <2.0 mg/dL or <34 µmol/L	2❑ Bilirubin 2.0-3.0 mg/dL or 34-52 µmol/L	3❑ Bilirubin 3.1-6.0 mg/dL or 53-103 µmol/L	4❑ Bilirubin 6.1-15.0 mg/dL or 104-256 µmol/L	5❑ Bilirubin >15.0 mg/dL or >256 µmol/L

61. Other organ involvement?

1❑ Yes
0❑ No

	Yes	No	
62.	1❑	0❑	Upper GI tract
63.	1❑	0❑	Lung
64.	1❑	0❑	Other

65. Specify: _____

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

66. Was specific therapy used to **treat** acute GVHD since last report? 1❑ Yes 0❑ No — Go to ***Q.113***

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? Yes	No
67.	ALS, ALG, ATS, ATG	0❑	1❑	2❑	3❑	**70.**	1❑	0❑
	68. Source: 1❑ Horse 2❑ Rabbit 3❑ Other, **69.** Specify: _____							
71.	Corticosteroids (systemic)	0❑	1❑	2❑	3❑	**72.**	1❑	0❑
73.	Corticosteroids (topical)	0❑	1❑	2❑	3❑	**74.**	1❑	0❑
75.	Cyclosporine (CSA) (e.g., Sandimmune, Neoral)	0❑	1❑	2❑	3❑	**76.**	1❑	0❑
77.	ECP (extra-corporeal photopheresis)	0❑	1❑	2❑	3❑	**78.**	1❑	0❑
79.	FK 506 (e.g., Tacrolimus, Prograf)	0❑	1❑	2❑	3❑	**80.**	1❑	0❑
81.	In vivo monoclonal antibody 1❑ Yes 0❑ No							
82.	Anti CD 25 (e.g., Zenapax, Daclizumab, AntiTAC)	0❑	1❑	2❑	3❑	**84.**	1❑	0❑
	83. Specify: _____							
85.	Campath	0❑	1❑	2❑	3❑	**86.**	1❑	0❑
87.	Etanercept (Enbrel)	0❑	1❑	2❑	3❑	**88.**	1❑	0❑
89.	Infliximab (Remicade)	0❑	1❑	2❑	3❑	**90.**	1❑	0❑
91.	OKT3 (e.g., Orthoclone)	0❑	1❑	2❑	3❑	**92.**	1❑	0❑
93.	Other	0❑	1❑	2❑	3❑	**95.**	1❑	0❑
	94. Specify antibody: _____							
96.	In vivo immunotoxin	0❑	1❑	2❑	3❑	**98.**	1❑	0❑
	97. Specify: _____							
99.	Methotrexate (MTX) (e.g., Amethopterin)	0❑	1❑	2❑	3❑	**100.**	1❑	0❑
101.	Mycophenolate mofetil (MMF) (e.g., Cellcept)	0❑	1❑	2❑	3❑	**102.**	1❑	0❑
103.	Sirolimus (e.g., Rapamycin, Rapamune)	0❑	1❑	2❑	3❑	**104.**	1❑	0❑
105.	Ursodiol	0❑	1❑	2❑	3❑	**106.**	1❑	0❑
107.	Blinded randomized trial	0❑	1❑	2❑	3❑	**109.**	1❑	0❑
	108. Specify agent being studied: _____							
110.	Other	0❑	1❑	2❑	3❑	**112.**	1❑	0❑
	111. Specify: _____							

* *for a therapeutic purpose*

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Chronic Graft-vs-Host Disease (GVHD)

113. Was chronic GVHD present at time of last report?

1 ❑ Yes
0 ❑ No — *Go to **Q.121***
8 ❑ Unknown

114. Has patient developed clinical chronic GVHD since date of last report?

1 ❑ Yes
0 ❑ No — *Go to **Q.208***
8 ❑ Unknown

115. Date of onset: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year) ❑ Date unknown (*Q.**116** = #1)*

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

1 ❑ Progressive (acute GVHD progressed directly to chronic GVHD)
2 ❑ Interrrupted (acute GVHD resolved, then chronic GVHD developed)
3 ❑ De novo (never developed acute GVHD)
4 ❑ Chronic GVHD flair (symptoms reactivated within 28 days of drug tapering or discontinuation)

117. Karnofsky/Lansky score at diagnosis of chronic GVHD: ☐☐☐ *(see **pg 1** for scores)*

118. Platelet count at diagnosis of chronic GVHD: ☐☐☐☐☐☐

Specify units for platelet count: 1❑ x10⁹/L (x10³/mm³) 2❑ x10⁶/L

119. Total serum bilirubin at diagnosis of chronic GVHD: ☐☐☐.☐

Specify units for bilirubin: 1❑ mg/dL 2❑ µmol/L

120. Diagnosis based on:

1 ❑ Histologic evidence
2 ❑ Clinical evidence
3 ❑ Both
8 ❑ Unknown

121. 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

122. 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:	**123.**	0❑	1❑	8❑	Subclinical (biopsy findings only)——*See **Q.120** #1*
	124.	0❑	1❑	8❑	Rash
	125.	0❑	1❑	8❑	Scleroderma
	126.	0❑	1❑	8❑	Lichenoid skin changes
	127.	0❑	1❑	8❑	Dyspigmentation
	128.	0❑	1❑	8❑	Alopecia
	129.	0❑	1❑	8❑	Body surface area
					130. Specific percent of BSA involved: ☐☐☐ %
	131.	0❑	1❑	8❑	Other skin/hair involvement,
					132. Specify: _____
Eyes:	**133.**	0❑	1❑	8❑	Dry eyes
	134.	0❑	1❑	8❑	Abnormal Schirmer's test
	135.	0❑	1❑	8❑	Corneal erosion/conjunctivitis
	136.	0❑	1❑	8❑	Other eye involvement
					137. Specify: _____
Mouth:	**138.**	0❑	1❑	8❑	Lichenoid changes
	139.	0❑	1❑	8❑	Mucositis/Ulcers
	140.	0❑	1❑	8❑	Other mouth involvement,
					141. Specify: _____
Lung:	**142.**	0❑	1❑	8❑	Bronchiolitis obliterans (BO, BOOP)——*See **Q.282***
	143.	0❑	1❑	8❑	Other lung involvement
					144. Specify: _____
GI Tract:	**145.**	0❑	1❑	8❑	Esophageal involvement
	146.	0❑	1❑	8❑	Chronic nausea/Vomiting
	147.	0❑	1❑	8❑	Chronic diarrhea
	148.	0❑	1❑	8❑	Malabsorption
	149.	0❑	1❑	8❑	Abdominal pain/cramps
	150.	0❑	1❑	8❑	Other GI tract involvement
					151. Specify: _____
Liver:	**152.**	0❑	1❑	8❑	Liver involvement
					153. Specify: _____
GU Tract:	**154.**	0❑	1❑	8❑	Vaginitis/Stricture
	155.	0❑	1❑	8❑	Other GU involvement
					156. Specify: _____
Musculoskeletal:	**157.**	0❑	1❑	8❑	Arthritis
	158.	0❑	1❑	8❑	Contractures
	159.	0❑	1❑	8❑	Myositis
	160.	0❑	1❑	8❑	Myasthenia
	161.	0❑	1❑	8❑	Other musculoskeletal involvement
					162. Specify: _____
Hematologic:	**163.**	0❑	1❑	8❑	Thrombocytopenia
	164.	0❑	1❑	8❑	Eosinophilia
	165.	0❑	1❑	8❑	Autoantibodies
	166.	0❑	1❑	8❑	Other hematologic involvement
					167. Specify: _____
Other:	**168.**	0❑	1❑	8❑	Serositis **169.** Specify site: _____
	170.	0❑	1❑	8❑	Weight loss
	171.	0❑	1❑	8❑	Other **172.** Specify: _____

TEAM: ____ IUBMID: ____

173. Were specific agents used to **treat** chronic GVHD since last report?

1 ❑ Yes
0 ❑ No

		No, drug not given	Drug continued from prophylaxis/aGVHD treatment	Yes, drug started
174.	ALS, ALG, ATS, ATG	0❑	1❑	2❑
	175. Source: 1❑Horse 2❑Rabbit 3❑Other, **176.** Specify: _____			
177.	Azathioprine	0❑	1❑	2❑
178.	Corticosteroids (systemic)	0❑	1❑	2❑
179.	Corticosteroids (topical)	0❑	1❑	2❑
180.	Cyclosporine (CSA) (e.g., Sandimmune, Neoral)	0❑	1❑	2❑
181.	ECP (extra-corporeal photopheresis)	0❑	1❑	2❑
182.	Etretinate	0❑	1❑	2❑
183.	FK 506 (e.g., Tacrolimus, Prograf)	0❑	1❑	2❑
184.	Hydroxychloroquine (Plaquenil)	0❑	1❑	2❑
185.	In vivo monoclonal antibody 1❑Yes 0❑No			
186.	Anti CD 25 (e.g., Zenapax, Daclizumab, AntiTAC))	0❑	1❑	2❑
	187. Specify: _____			
188.	Campath	0❑	1❑	2❑
189.	Etanercept (Enbrel)	0❑	1❑	2❑
190.	Infliximab (Remicade)	0❑	1❑	2❑
191.	OKT3 (e.g., Orthoclone)	0❑	1❑	2❑
192.	Other	0❑	1❑	2❑
	193. Specify: _____			
194.	Lamprene (Cofa[illegible]mine)	0❑	1❑	2❑
195.	Mycophenolate mofetil (MMF) (e.g., Cellcept)	0❑	1❑	2❑
196.	Pentostatin	0❑	1❑	2❑
197.	PUVA (Psoralen and UVA)	0❑	1❑	2❑
198.	Sirolimus (e.g., Rapamycin, Rapamune)	0❑	1❑	2❑
199.	Thalidomide	0❑	1❑	2❑
200.	Ursodiol	0❑	1❑	2❑
201.	Blinded randomized trial	0❑	1❑	2❑
	202. Specify agent being studied: _____			
203.	Other	0❑	1❑	2❑
	204. Specify: _____			

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

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

206. Date last treatment was administered: ____ ____ ____ ____ ____ ____ ____ ____ ❑ Unknown
Month Day Year

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

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

208. Did patient develop clinically significant infection since date of last report?

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 13 & Infection Sites Codes on pg 15)

	Yes	No		Site	Organism	Date of Onset: Month	Day	Year
209. Bacterial	1❑	0❑						
Typical			First	**210.** ☐☐	**211.** T☐☐☐	**212.** ☐☐	☐☐	☐☐☐☐
			Second	**213.** ☐☐	**214.** T☐☐☐	**215.** ☐☐	☐☐	☐☐☐☐
Atypical			First	**216.** ☐☐	**217.** B☐☐☐	**218.** ☐☐	☐☐	☐☐☐☐
			Second	**219.** ☐☐	**220.** B☐☐☐	**221.** ☐☐	☐☐	☐☐☐☐

222. If code 119, specify: _____

223. Fungal	1❑	0❑						
			First	**224.** ☐☐	**225.** F☐☐☐	**226.** ☐☐	☐☐	☐☐☐☐
			Second	**227.** ☐☐	**228.** F☐☐☐	**229.** ☐☐	☐☐	☐☐☐☐

230. If code 209,219 or 259, specify: _____

231. Viral	1❑	0❑						
			First	**232.** ☐☐	**233.** V☐☐☐	**234.** ☐☐	☐☐	☐☐☐☐
			Second	**235.** ☐☐	**236.** ☐☐☐☐	**237.** ☐☐	☐☐	☐☐☐☐

238. If code 323, specify: _____

239. Parasitic	1❑	0❑						
			First	**240.** ☐☐	**241.** P☐☐☐	**242.** ☐☐	☐☐	☐☐☐☐
			Second	**243.** ☐☐	**244.** P☐☐☐	**245.** ☐☐	☐☐	☐☐☐☐

246. If code 409, specify: _____

247. Other infections *(do not report fever in the absence of a specific site of infection)*	1❑	0❑						
			First	**248.** ☐☐	**249.** O☐☐☐	**250.** ☐☐	☐☐	☐☐☐☐
			Second	**251.** ☐☐	**252.** O☐☐☐	**253.** ☐☐	☐☐	☐☐☐☐

254. 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.247-253)

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, bovium, intracellulare)
113 = Chlamydia
119 = Other atypical bacteria, *specify in* ***Q.223***
501 = Suspected atypical bacterial infection

Typical Bacteria

120 = Typical bacteria, NOS
121 = Acinetobacter
122 = Actinomyces
123 = Bacillus
124 = Bacteroides (gracillis, uniformis, vulgaris, other sp.)
125 = Bordetella
126 = Borrelia (Lyme disease)
127 = Branhamelia 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-diptheria 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 (bulgaricus, acidophilus, other sp.)
148 = Leptotrichia buccalis
149 = Leuconostoc (all sp.)
150 = Methylobacterium
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 mucilaginosis
167 = Streptococcus (all sp., except Enterococcus)
168 = Treponema (syphilis)
169 = Vibrio (all sp.)
170 = Other bacteria
198 = Other bacteria, *specify in* ***Q.223***
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 subspecies of candida)
209 = Other Candida, *specify in* ***Q.231***
210 = Aspergillus, NOS
211 = Aspergillus flavus
212 = Aspergillus fumigatus
213 = Aspergillus niger
219 = Other Aspergillus, *specify in* ***Q.231***
220 = Cryptococcus sp.
230 = Fusarium sp.
240 = Mucormycosis (zygomycetes, rhizopus)
250 = Yeast, NOS
251 = Other fungus, *specify in* ***Q.231***
260 = Pneumocystis (PCP)
503 = 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.239***
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.247***
505 = Suspected parasite infection

Other Infections

509 = No organism identified

Cust Fig A-56

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Pulmonary function

255. Has patient developed interstitial pneumonitis (IPn or ARDS) since last report?

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.

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

1❑ Yes
0❑ No

257. Total number of prior episodes since first HSCT: ☐

258. Date of onset: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

259. Were diagnostic tests other than radiographic studies done?

1❑ Yes
0❑ No
8❑ Unknown

	Yes	No	Unknown	
260.	1❑	0❑	8❑	Bronchoalveolar lavage (BAL)
261.	1❑	0❑	8❑	Transbronchial biopsy
262.	1❑	0❑	8❑	Open/thoracoscopic (VATS) lung biopsy
263.	1❑	0❑	8❑	Autopsy
264.	1❑	0❑	8❑	Other

265. Specify: _____

266. Was an organism isolated?

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

	Yes	No	Unknown	
267.	1❑	0❑	8❑	Pneumocystis carinii (PCP)
268.	1❑	0❑	8❑	Aspergillus
269.	1❑	0❑	8❑	Candida
270.	1❑	0❑	8❑	Toxoplasma
271.	1❑	0❑	8❑	Respiratory syncytial virus (RSV)
272.	1❑	0❑	8❑	Cytomegalovirus (CMV)
273.	1❑	0❑	8❑	Herpes simplex (HSV1, HSV2)
274.	1❑	0❑	8❑	Adenovirus
275.	1❑	0❑	8❑	Human herpes virus 6 (HHV-6)
276.	1❑	0❑	8❑	Other virus

277. Specify: _____

278. 1❑ 0❑ 8❑ Other

279. Specify: _____

(Report bacterial pneumonia, Q.209)

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

1❑ Yes
0❑ No

Copy this page and complete Qs.258-279 for each subsequent episode

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

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

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

282. Did patient develop bronchiolitis obliterans?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

283. Date of onset: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

284. Were diagnostic tests done?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

	Yes	No	Unknown	
285.	1❑	0❑	8❑	Bronchoalveolar lavage (BAL)
286.	1❑	0❑	8❑	Transbronchial biopsy
287.	1❑	0❑	8❑	Open/thorascopic (VATS) lung biopsy
288.	1❑	0❑	8❑	Autopsy
289.	1❑	0❑	8❑	Other

290. Specify: _____

291. Did patient develop pulmonary hemorrhage?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

292. Date of onset: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

293. Were diagnostic tests done?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

	Yes	No	Unknown	
294.	1❑	0❑	8❑	Bronchoalveolar lavage (BAL)
295.	1❑	0❑	8❑	Transbronchial biopsy
296.	1❑	0❑	8❑	Open/thorascopic (VATS) lung biopsy
297.	1❑	0❑	8❑	Autopsy
298.	1❑	0❑	8❑	Other

299. Specify: _____

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

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

301. Specify: _____

Common Sites of Infection Codes

1 = Blood/buffy coat
2 = Disseminated – generalized, or involving 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

Stnd Fig A-55

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

302. Did patient develop any other non-infectious clinically signicant organ impairment or disorder since last report?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

	Yes	No	
303.	1❑	0❑	Renal failure severe enough to warrant dialysis
304.			Received dialysis? 1❑ Yes 0❑ No
305.	1❑	0❑	Posttransplant microangiopathythrombotic thrombocytopenic purpura (TTP) hemolytic uremic syndrome (HUS) or similar syndrome
306.	1❑	0❑	Depression
307.	1❑	0❑	Hemorrhage cystitis
308.	1❑	0❑	Seizures
309.	1❑	0❑	Avascular necrosis
310.	1❑	0❑	Cataracts
311.	1❑	0❑	Gonadal dysfunction
312.	1❑	0❑	Hypothyroidism
313.	1❑	0❑	Growth hormone deficiency/growth disturbance
314.	1❑	0❑	Myocardial infarction
315.	1❑	0❑	Cirrhosis
316.	1❑	0❑	Veno-occlusive disease (VOD)
317.	1❑	0❑	Other
318.			Specify: _____

319. Has the patient or partner become pregnant since last report?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

	Yes	No	N/A	Unk	
320.	1❑	0❑	7❑	8❑	Fathered a child with cryopreserved sperm
321.	1❑	0❑	7❑	8❑	Fathered a child naturally
322.	1❑	0❑	7❑	8❑	Had a live birth

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

323. Did a new malignancy, lymphoproliferative or myeloproliferative disorder appear since last report (not a relapse, progression or transformation of the disease for which the original transplant was performed) post-DCI?

1 ❑ Yes
0 ❑ No
8 ❑ Unknown

324. Did more than one new malignancy develop?

1❑ Yes
0❑ No

325. 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.326-340 for each

326. Date of diagnosis: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

327. Origin of cells: 1❑ Host 2❑ Donor 8❑ Unknown

Diagnosis:

	Yes	No	
328.	1❑	0❑	Clonal cytogenetic abnormality without leukemia or MDS
329.	1❑	0❑	Acute myeloid leukemia (AML, ANLL)
330.	1❑	0❑	Other leukemia
331.			Specify: _____
332.	1❑	0❑	Myelodysplasia (MDS)/myeloproliferative (MPS) disorder
333.	1❑	0❑	Lymphoma or lymphoproliferative disease
334.			EBV positive: 1❑ Yes 0❑ No 8❑ Unknown
335.	1❑	0❑	Hodgkin disease
336.	1❑	0❑	Other cancer

Please translate into English and print neatly

337. Primary site: _____

338. Histologic type: _____

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

340. 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.323

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Subsequent HSCT*

Complete this section if a subsequent HSCT was received (see Q.18). Answers on pgs 12-17 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

341. Date of subsequent HSCT: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

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

342. Reason for subsequent HSCT *(check only one)*:

1 ☐ No engraftment
2 ☐ Partial engraftment
3 ☐ Late graft failure

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

4 ☐ Persistent malignancy
5 ☐ Relapse
6 ☐ Planned second HSCT, per protocol
8 ☐ Secondary/new malignancy — *Complete new malignancy **Qs.323-340***
90 ☐ Other reason

343. Specify: _____

344. Type of graft *(check only one)*:

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

345. Donor *(check only one)*:

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

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

1 ☐ Yes
0 ☐ No

347. Specify:

Name: _____
City: _____ State: _____
Country: _____

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Subsequent DCI*

Complete this section if a subsequent DCI was received >28 days from the first DCI infusion for this Report Form (see Q.19). Answers on pgs 6-18 of this report should reflect clinical status immediately prior to subsequent DCI.

A separate Day 100 DCI Report Form must be submitted

348. Date first subsequent DCI given: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

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

349. Was infusion performed at a different institution?

1 ❑ Yes

0 ❑ No

350. Specify:

Name: _____

City: _____ State: _____

Country: _____

351. If patient received a DCI >14 days post-HSCT or >28 days after the prior DCI, was therapy given to treat the patient's disease between the last HSCT/DCI and the next reportable DCI?

1 ❑ Yes

0 ❑ No

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

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Death Information

352. Date of death: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

Cause(s) of death:

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

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

Contributing or secondary causes:

354. ☐☐☐ — If code 29, 39, 88, 89, 109, 129 or 900, specify: _____

355. ☐☐☐ — If code 29, 39, 88, 89, 109, 129 or 900, specify: _____

356. ☐☐☐ — If code 29, 39, 88, 89, 109, 129 or 900, specify: _____

357. ☐☐☐ — If code 29, 39, 88, 89, 109, 129 or 900, specify: _____

358. ☐☐☐ — If code 29, 39, 88, 89, 109, 129 or 900, specify: _____

359. Was cause of death confirmed by autopsy?

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

360. 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.359

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

(this malignancy must be reported on first transplant form as "co-existing disease" pre-transplant)

900 Other, specify

Stnd Fig A-58

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

Log of Appended Documents

361. Number of attached documents: ☐☐

Attach as many documents as indicated thoughout 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
362. ☐☐ ☐☐ ☐☐☐☐ Month Day Year	1❑ Bone marrow biopsy/aspirate 2❑ Cytogenetics 3❑ FISH 4❑ HLA 5❑ Laboratory 6❑ Molecular tests 7❑ Pathology/Autopsy 8❑ Copied page of Day 100 F.U., specify page # ☐☐ 77❑ Other, specify: _____	❑ CORE Follow-up Insert ❑ Disease-specific Insert Page_____ Question_____
363. ☐☐ ☐☐ ☐☐☐☐ Month Day Year	1❑ Bone marrow biopsy/aspirate 2❑ Cytogenetics 3❑ FISH 4❑ HLA 5❑ Laboratory 6❑ Molecular tests 7❑ Pathology/Autopsy 8❑ Copied page of Day 100 F.U., specify page # ☐☐ 77❑ Other, specify: _____	❑ CORE Follow-up Insert ❑ Disease-specific Insert Page_____ Question_____
364. ☐☐ ☐☐ ☐☐☐☐ Month Day Year	1❑ Bone marrow biopsy/aspirate 2❑ Cytogenetics 3❑ FISH 4❑ HLA 5❑ Laboratory 6❑ Molecular tests 7❑ Pathology/Autopsy 8❑ Copied page of Day 100 F.U., specify page # ☐☐ 77❑ Other, specify: _____	❑ CORE Follow-up Insert ❑ Disease-specific Insert Page_____ Question_____
365. ☐☐ ☐☐ ☐☐☐☐ Month Day Year	1❑ Bone marrow biopsy/aspirate 2❑ Cytogenetics 3❑ FISH 4❑ HLA 5❑ Laboratory 6❑ Molecular tests 7❑ Pathology/Autopsy 8❑ Copied page of Day 100 F.U., specify page # ☐☐ 77❑ Other, specify: _____	❑ CORE Follow-up Insert ❑ Disease-specific Insert Page_____ Question_____
366. ☐☐ ☐☐ ☐☐☐☐ Month Day Year	1❑ Bone marrow biopsy/aspirate 2❑ Cytogenetics 3❑ FISH 4❑ HLA 5❑ Laboratory 6❑ Molecular tests 7❑ Pathology/Autopsy 8❑ Copied page of Day 100 F.U., specify page # ☐☐ 77❑ Other, specify: _____	❑ CORE Follow-up Insert ❑ Disease-specific Insert Page_____ Question_____

Follow-up Institutional Information

FOR REGISTRY USE ONLY:

I.D. ☐ – ☐☐☐☐ – ☐☐☐☐☐☐

Date received:

*Log:*_____ *PC:*_____

TEAM: ☐☐☐☐ IUBMID: ☐☐☐☐☐☐

(Institutional Unique Blood or Marrow Transplant Identification Number)

Registry (circle one): IBMTR ABMTR

Date of transplant for which this form is being completed: ☐☐ ☐☐ ☐☐☐☐ (Month Day Year)

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 follow-up report of transplant consists of the following two parts *(both parts should have the same date of report, date of transplant and contact date)*:

¹ A (white) CORE Follow-up Insert

² An appropriate (ivory) Follow-up disease-specific insert

Report Form = ***CORE Follow-up Insert*** + ***Follow-up Disease Insert***

viii. Was a reportable transplant or infusion, as defined on ***pgs 3 & 18*** performed since last report?

1 ☐ Yes

0 ☐ No

ix. Was conditioning given for subsequent transplant?

1 ☐ Yes — ***Cut off for this Follow-up Report Form is one day prior to conditioning start date***

0 ☐ No — ***Cut off for this Follow-up Report Form is one day prior to the subsequent infusion***

x. Was patient alive on Day of Last Contact for this Follow-up Report Form?

1 ☐ Yes — *The last contact date for all parts of this Follow-up Report Form is date of the follow-up exam closest to the transplant anniversary date*

0 ☐ No — *The last contact date for all parts of this Follow-up Report Form should be the date of death*

Enter date of last contact on pg 1 of the 002-COREFU Follow-up Insert.

NOTE: Report information in the CORE Follow-up Insert and Follow-up 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.

If completing a Follow-up Report Form for >2 years of data, report all data on one Follow-up Report Form. Begin completing annual Follow-up Report Forms thereafter.