

DCI SUPPLEMENT INSERT
Waldenstrom's Macroglobulinemia

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


TEAM:

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

Registry (circle one): **IBMTR** **ABMTR**

1. Date of first DCI for which this form is being completed:
 / /
 Month Day Year

2. Date of report: / /
 Month Day Year

<p>DCI Disease Supplement Inserts</p>		<p>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 Email: ibmtr@mcw.edu</p>
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If answer on 002-DCI Insert, Q.513 is "No", **do not submit this insert** to the IBMTR.

Information

Copy this page for recording more instances

Line of Therapy						2nd			
BIOPSY:	3.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	25.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
SURGERY:	4.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	26.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
RADIATION THERAPY:	5.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	27.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Specify sites:	6.	_____		28.	_____				
		_____			_____				
CHEMOTHERAPY:	7.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	29.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
# of cycles:	8.	<input type="text"/>	8 <input type="checkbox"/> Unk or Not App	30.	<input type="text"/>	8 <input type="checkbox"/> Unk or Not App			
Treatment									
2-chloro-deoxyadenosine (2-CDA):	9.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	31.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Adriamycin:	10.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	32.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Anti CD-20 antibody:	11.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	33.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Chlorambucil:	12.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	34.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Cyclophosphamide:	13.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	35.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Etoposide (VP16):	14.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	36.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Fludarabine:	15.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	37.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Idarubicin:	16.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	38.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Ifosfamide:	17.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	39.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Melphalan (LPAM):	18.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	40.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Mitoxantrone:	19.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	41.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Steroids:	20.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	42.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Vinblastine:	21.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	43.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Vincristine (VCR):	22.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No	44.	1 <input type="checkbox"/> Yes	0 <input type="checkbox"/> No			
Other:	23.	1 <input type="checkbox"/> Yes		45.	1 <input type="checkbox"/> Yes				
Specify other:	24.	_____		46.	_____				