National Marrow Donor Program®
Recipient Baseline and Transplant Data

Registry Use Only

Sequence Number:

Date Received:

Unrelated Recipient NMDP ID: ___ - ___ - ___

Recipient Last Name:

Recipient Local ID (optional):

Donor or Cord NMDP ID*: ___ - ___ - ___

* For multiple cord blood units infused, see page 15 for additional Cord ID boxes.

Today's Date: Month ___ Day ___ Year 20__ TC Code: ___

Date of Transplant for which this form is being completed: Month ___ Day ___ Year 20__

Product type: ☐ Marrow (Form 120) ☐ PBSC (Form 520) ☐ Cord blood (Form 620) ☐ Multiple cord blood units infused

Research blood samples should be collected before initiation of preparative regimen and sent to Blood Centers of the Pacific, Irwin Center. See Transplant Center Manual of Operations for instructions.

1. Recipient name (please print) *(optional)*: _____ LAST _____ FIRST

Reg Use Only ___

2. a. State of residence of recipient (for residents of USA): _____

   b. Zip or postal code for place of recipient's residence (USA recipients only): ___

   c. Country if non-resident of USA: _____

3. Does the recipient have a U.S. Social Security Number (or Canadian Social Insurance Number)? *(optional)*
   1 ☐ yes → 4. Social Security Number / Social Insurance Number: ___
   2 ☐ no
   3 ☐ Transplant Center not allowed to report this information

5. Sex:
   1 ☐ male
   2 ☐ female

6. Ethnicity:
   1 ☐ Hispanic or Latino
   2 ☐ not Hispanic or Latino

Mail a copy of this form to:
The NMDP Registry
Suite 500
3001 Broadway Street N.E.
Minneapolis, MN 55413
Retain original at the Transplant Center.

NMDP Form 0120, 0520, 0620 v12.0 (1–15) May 2005

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Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

7. Race: (Mark which group(s) the recipient is a member of. Check all that apply.)

White
1 ☐ Eastern European
2 ☐ Mediterranean
3 ☐ Middle Eastern
4 ☐ North Coast of Africa
5 ☐ North American
6 ☐ Northern European
7 ☐ Western European
8 ☐ White Carribbean
9 ☐ White South or Central American
10 ☐ Other White

Black
11 ☐ African (both parents born in Africa)
12 ☐ African American
13 ☐ Black Caribbean
14 ☐ Black South or Central American

American Indian or Alaska Native
15 ☐ Alaskan Native or Aleut
16 ☐ North American Indian
17 ☐ American Indian, South or Central America
18 ☐ Caribbean Indian

Asian
19 ☐ South Asian
20 ☐ Filipino (Pilipino)
21 ☐ Japanese
22 ☐ Korean
23 ☐ Chinese
24 ☐ Vietnamese
25 ☐ Other Southeast Asian

Native Hawaiian or Other Pacific Islander
26 ☐ Guamanian
27 ☐ Hawaiian
28 ☐ Samoan
29 ☐ Other Pacific Islander

Decline
30 ☐ Patient declines to provide race

8. Date of birth: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

9. What was the primary disease for which the transplant was performed?

1 ☐ Acute myelogenous leukemia (AML) →
- 1 ☐ M0
- 2 ☐ M1, myeloblastic
- 3 ☐ M2, myelocytic
- 4 ☐ M3, promyelocytic (APML, APL)
- 5 ☐ M4, myelomonocytic (AMML)
- 6 ☐ M5, monocytic (AMMOL)
- 7 ☐ M6, erythroblastic (AEL)
- 8 ☐ M7, megakaryoblastic
- 9 ☐ Granulocytic sarcoma
- 10 ☐ Other, specify: _____
- 11 ☐ Unknown

Please Complete Form 120, 520, 620 – Insert I

2 ☐ Acute lymphoblastic leukemia (ALL) →
- 1 ☐ Mature B-cell (L3)
- 2 ☐ T-cell
- 3 ☐ Null cell (early pre-B)
- 4 ☐ cALLa (includes pre-B)
- 5 ☐ B-lineage
- 6 ☐ Other, specify: _____
- 7 ☐ Unknown

Please Complete Form 120, 520, 620 – Insert II

3 ☐ Chronic myelogenous leukemia →
- 1 ☐ Ph[1]+; BCR/ABL+
- 2 ☐ Ph[1]+; BCR/ABL–
- 3 ☐ Ph[1]+; BCR/ABL unknown
- 4 ☐ Ph[1]–; BCR/ABL+
- 5 ☐ Ph[1]–; BCR/ABL–
- 6 ☐ Ph[1]–; BCR/ABL unknown
- 7 ☐ Ph[1] unknown; BCR/ABL+
- 8 ☐ Ph[1] unknown; BCR/ABL–
- 9 ☐ Ph[1] unknown; BCR/ABL unknown

Please Complete Form 120, 520, 620 – Insert III

4 ☐ Other leukemia →
- 1 ☐ Acute undifferentiated leukemia
- 2 ☐ Biphenotypic, bilineage or hybrid leukemia
- 3 ☐ Acute mast cell leukemia
- 4 ☐ Chronic lymphocytic leukemia (CLL)
- 5 ☐ Hairy cell leukemia
- 6 ☐ Juvenile CML (no evidence of Philadelphia chromosome or BCR/ABL)
- 7 ☐ Prolymphocytic leukemia (PLL)
- 8 ☐ Other, specify: _____
- 9 ☐ Unknown

Please Complete Form 120, 520, 620 – Insert IV

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5 ☐ Myelodysplastic/ myeloproliferative disorders (Please classify all preleukemias)

(If recipient has transformed to AML, indicate AML as the primary disease) →

1 ☐ Refractory anemia (RA)
2 ☐ Refractory anemia with excess blasts (RAEB)
3 ☐ Refractory anemia with excess blasts in transformation (RAEBT)
4 ☐ Chronic myelomonocytic leukemia (CMML)
5 ☐ Acquired idiopathic sideroblastic anemia (RARS)
6 ☐ Paroxysmal nocturnal hemoglobinuria (PNH)
7 ☐ Polycythemia vera
8 ☐ Essential or primary thrombocythemia
9 ☐ Myelofibrosis with myeloid metaplasia
10 ☐ Other myelofibrosis or myelosclerosis
11 ☐ Other myelodysplasia or myeloproliferative disorder, specify: _____
12 ☐ Unknown

Please Complete Form 120, 520, 620 – Insert V

6 ☐ Non-Hodgkin lymphoma →

1 ☐ Small cell lymphocytic
2 ☐ Small cell lymphocytic plasmacytoid (Lymphoplasmacytoid lymphoma)
3 ☐ Follicular, predominantly small cleaved cell (Grade I follicle center lymphoma)
4 ☐ Follicular, mixed, small cleaved and large cell (Grade II follicle center lymphoma)
5 ☐ Follicular, predominantly large cell (Grade III follicle center lymphoma)
6 ☐ Diffuse, small cleaved cell (Follicular center lymphoma, diffuse)
7 ☐ Diffuse, mixed, small and large cell
8 ☐ Diffuse, large cell
9 ☐ Large cell, immunoblastic (B-cell only)
10 ☐ Primary mediastinal large B-cell lymphoma
11 ☐ Lymphoblastic (Precursor B-lymphoblastic lymphoma/ leukemia)
12 ☐ Precursor T-lymphoblastic lymphoma/leukemia
13 ☐ Small noncleaved cell, unclassified
14 ☐ Small noncleaved cell, Burkitt
15 ☐ Small noncleaved cell, non-Burkitt
16 ☐ Mycosis fungoides/Sezary syndrome
17 ☐ Histiocytic
18 ☐ Mantle cell
19 ☐ Composite, specify: _____
20 ☐ Large cell anaplastic lymphoma, Ki1 positive
21 ☐ Primary CNS lymphoma
22 ☐ Mucosal associated lymphoid tissue type (Extranodal marginal zone B-cell lymphoma)
23 ☐ Nodal marginal zone B-cell lymphoma
24 ☐ Splenic marginal zone B-cell lymphoma
25 ☐ Large granular lymphocytic leukemia
26 ☐ Angioimmunoblastic T-cell lymphoma
27 ☐ Angiocentric lymphoma
28 ☐ Intestinal T-cell lymphoma
29 ☐ Adult T-cell lymphoma/leukemia (HTLV1 associated)
30 ☐ Other peripheral T-cell lymphoma, specify: _____
31 ☐ Peripheral T-cell lymphomas, unclassified
32 ☐ Other non-Hodgkin lymphoma, specify: _____
33 ☐ Non-Hodgkin lymphoma, unclassified

Please Complete Form 120, 520, 620 – Insert IX

7 ☐ Hodgkin lymphoma →

1 ☐ Lymphocyte predominant
2 ☐ Nodular sclerosis
3 ☐ Mixed cellularity
4 ☐ Lymphocyte depleted
5 ☐ Other Hodgkin lymphoma
6 ☐ Hodgkin lymphoma, type unclassified

Please Complete Form 120, 520, 620 – Insert IX

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Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

8 ☐ Multiple myeloma/ plasma cell disorder →

1 ☐ Multiple myeloma

Please Complete Form 120, 520, 620 – Insert VI

2 ☐ Plasma cell leukemia
3 ☐ Waldenstrom macroglobulinemia
4 ☐ Other, specify: _____
5 ☐ Unknown

Continue with Question 10 on page 6

9 ☐ Other malignancies →

1 ☐ Neuroblastoma
2 ☐ Breast cancer
3 ☐ Ewing sarcoma
4 ☐ Small cell lung cancer
5 ☐ Central nervous system tumors
6 ☐ Other, specify: _____

Please Complete Form 120, 520, 620 – Insert XII

7 ☐ Renal cell carcinoma

Please Complete Form 120, 520, 620 – Insert XVIII

10 ☐ Severe aplastic anemia (If recipient has developed leukemia, complete insert for appropriate leukemic diagnosis) →

1 ☐ Idiopathic
2 ☐ Secondary to hepatitis
3 ☐ Secondary to toxin/ other drug
4 ☐ Amegakaryocytosis (not congenital)
5 ☐ Fanconi anemia
6 ☐ Diamond-Blackfan anemia (pure red cell aplasia)
7 ☐ Other, specify: _____
8 ☐ Unknown

Please Complete Form 120, 520, 620 – Insert VIII

11 ☐ Inherited abnormalities of erythrocyte differentiation or function →

1 ☐ Thalassemia major (ß thalassemia)
2 ☐ Sickle cell anemia
3 ☐ Other hemoglobinopathy, specify: _____
4 ☐ Other, specify: _____

Continue with Question 10 on page 6

12 ☐ Severe combined immunodeficiency (SCID) and other disorders primarily affecting the immune system →

1 ☐ Adenosine deaminase (ADA) deficiency – SCID
2 ☐ Absence of T and B cells – SCID
3 ☐ Absence of T, normal B cell – SCID
4 ☐ Omenn syndrome
5 ☐ Reticular dysgenesis
6 ☐ Bare lymphocyte syndrome
7 ☐ Other SCID, specify: _____

Please Complete Form 120, 520, 620 – Insert X

8 ☐ Wiskott-Aldrich syndrome

Please Complete Form 120, 520, 620 – Insert XI

9 ☐ Chediak-Higashi syndrome

Please Complete Form 120, 520, 620 – Insert XV

10 ☐ X-linked lympho-proliferative syndrome

Please Complete Form 120, 520, 620 – Insert XVII

11 ☐ Ataxia telangiectasia
12 ☐ HIV infection
13 ☐ DiGeorge anomoly
14 ☐ Chronic granulomatous disease
15 ☐ Common variable immunodeficiency
16 ☐ Leukocyte adhesion deficiency (Gp-180 deficiency, CD-18 deficiency, LFA deficiency, WBC adhesion deficiency)
17 ☐ Kostmann neutropenia
18 ☐ Neutrophil actin deficiency
19 ☐ Cartilage – hair hypoplasia
20 ☐ Combined immuno-deficiency disease, specify: _____
21 ☐ Other immunodeficiences, specify: _____
22 ☐ Immune system disorders unknown

Continue with Question 10 on page 6

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

13 ☐ Inherited abnormalities of platelets →

1 ☐ Amegakaryocytosis/ congenital thrombo-cytopenia
2 ☐ Glanzmann thrombasthenia
3 ☐ Other, specify: _____
4 ☐ Unknown inherited platelet disorder

Continue with Question 10 on page 6

14 ☐ Inherited disorders of metabolism →

1 ☐ Krabbe disease (globoid cell leukodystrophy)
2 ☐ Metachromatic leukodystrophy
3 ☐ Adrenoleukodystrophy

Please Complete Form 120, 520, 620 – Insert XIII

Mucopolysaccharidoses

4 ☐ α-L-iduronidase (Hunter – MPS I)
5 ☐ Iduronate sulfatase (Hunter – MPS II)
6 ☐ Heparan N-sulfatase (Sanfilippo A – MPS IIIA)
7 ☐ α-N-acetylglucosaminidase (Sanfilippo B – MPS IIIB)
8 ☐ Acetyl CoA: α-glucosaminide acetyltransferase (Sanfilippo C – MPS IIIC)
9 ☐ N-acetylglucosamine 6-sulfatase (Sanfilippo D – MPS IIID)
10 ☐ Galactose 6-sulfatase (Morquio A – MPS IVA)
11 ☐ β-galactosidase (Morquio B – MPS IVB)
12 ☐ N-acetyl galactosamine 4-sulfatase (Maroteaux-Lamy – MPS VI)
13 ☐ β-glucuronidase (Sly syndrome – MPS VII)

Other Storage Diseases

14 ☐ Glucocerebrosidase (Gaucher)
15 ☐ Acid sphingomyelinase (Niemann-Pick)
16 ☐ Phosphotransferase (Mucolipidosis II or I-cell)
17 ☐ Acid lipase (Wolman)
18 ☐ α-fucosidase (Fucosidosis)
19 ☐ Neuronal ceroid-lipofuscinosis enzyme – NCL 1 (infantile): PPT-palmitoyl protein thioesterase
20 ☐ Neuronal ceroid-lipofuscinosis enzyme – NCL 2 (classic late infantile): transpeptidase
21 ☐ α- or β-mannosidase (Mannosidosis)
22 ☐ Aspartyl glucosaminidase (Aspartylglucosaminuria)
23 ☐ Hypoxanthine-guanine phosphoribosyltransferase (Lesch-Nyhan)
24 ☐ Other storage disease, specify: _____

Please Complete Form 120, 520, 620 – Insert XIV

25 ☐ Osteopetrosis (malignant infantile osteopetrosis)
26 ☐ Unknown inherited metabolic disorder

Continue with Question 10 on page 6

15 ☐ Histiocytic disorders →

1 ☐ Familial erythrophagocytic lymphohistiocytosis (FEL) (Familial hemophagocytic lymphohistiocytosis)

Please Complete Form 120, 520, 620 – Insert XVI

2 ☐ Histiocytosis-X
3 ☐ Hemophagocytosis
4 ☐ Other, specify: _____

Continue with Question 10 on page 6

16 ☐ Other non-malignant disease →

Specify: _____

Continue with Question 10 on page 6

Recipient NMDP ID: | | | | - | | | | - | |

Recipient Last Name: | | | | | | | | | | | | | | | |

Clinical Status of Recipient Prior to Conditioning

10. What is the recipient's blood type?

1 ☐ A positive
2 ☐ A negative
3 ☐ B positive
4 ☐ B negative
5 ☐ AB positive
6 ☐ AB negative
7 ☐ O positive
8 ☐ O negative

11. What was the functional status of the recipient prior to conditioning?

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

KARNOFSKY SCALE ≥ 16 yrs

Check the phrase in the Karnofsky Scale which best describes the activity status of the recipient:

Able to carry on normal activity; no special care is needed

1 ☐ 100 Normal; no complaints; no evidence of disease
2 ☐ 90 Able to carry on normal activity
3 ☐ 80 Normal activity with effort

Unable to work; able to live at home, cares for most personal needs; a varying amount of assistance is needed

4 ☐ 70 Cares for self; unable to carry on normal activity or to do active work
5 ☐ 60 Requires occasional assistance but is able to care for most needs
6 ☐ 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

7 ☐ 40 Disabled; requires special care and assistance
8 ☐ 30 Severely disabled; hospitalization indicated, although death not imminent
9 ☐ 20 Very sick; hospitalization necessary
10 ☐ 10 Moribund; fatal process progressing rapidly

LANSKY SCALE < 16 yrs

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

Able to carry on normal activity; no special care is needed

1 ☐ 100 Fully active
2 ☐ 90 Minor restriction in physically strenuous play
3 ☐ 80 Restricted in strenuous play, tires more easily, otherwise active

Mild to moderate restriction

4 ☐ 70 Both greater restrictions of, and less time spent in, active play
5 ☐ 60 Ambulatory up to 50% of time, limited active play with assistance/supervision
6 ☐ 50 Considerable assistance required for any active play; fully able to engage in quiet play

Moderate to severe restriction

7 ☐ 40 Able to initiate quiet activities
8 ☐ 30 Needs considerable assistance for quiet activity
9 ☐ 20 Limited to very passive activity initiated by others (e.g., TV)
10 ☐ 10 Completely disabled, not even passive play

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12. Were there clinically significant coexisting diseases at any time prior to conditioning?
    1 ☐ yes →
    2 ☐ no

13. Indicate the diagnoses:
    a. 1 ☐ yes 2 ☐ no significant hemorrhage (e.g., CNS or GI), specify site(s): _____
    b. 1 ☐ yes 2 ☐ no coronary artery disease
    c. 1 ☐ yes 2 ☐ no hypertension
    d. 1 ☐ yes 2 ☐ no other cardiac disease, specify: _____
    e. 1 ☐ yes 2 ☐ no diabetes mellitus
    f. 1 ☐ yes 2 ☐ no thyroid disease
    g. 1 ☐ yes 2 ☐ no other endocrine disease, specify: _____
    h. 1 ☐ yes 2 ☐ no seizure disorder
    i. 1 ☐ yes 2 ☐ no other CNS disease, specify: _____
    j. 1 ☐ yes 2 ☐ no asthma
    k. 1 ☐ yes 2 ☐ no other pulmonary disease, specify: _____
    l. 1 ☐ yes 2 ☐ no genitourinary disease, specify: _____
    m. 1 ☐ yes 2 ☐ no gastrointestinal disease, specify: _____
    n. 1 ☐ yes 2 ☐ no hematologic disease, specify: _____
    o. 1 ☐ yes 2 ☐ no Fanconi anemia
    p. 1 ☐ yes 2 ☐ no Down syndrome
    q. 1 ☐ yes 2 ☐ no other chromosomal disorder, specify: _____
    r. 1 ☐ yes 2 ☐ no history of other malignancy, specify: _____
    s. 1 ☐ yes 2 ☐ no neonatal GEMI
    t. 1 ☐ yes 2 ☐ no rheumatoid arthritis
    u. 1 ☐ yes 2 ☐ no systemic lupus erythematosis
    v. 1 ☐ yes 2 ☐ no liver disease, specify: _____
    w. 1 ☐ yes 2 ☐ no multiple sclerosis
    x. 1 ☐ yes 2 ☐ no polyarteritis nodosa
    y. 1 ☐ yes 2 ☐ no psoriasis
    z. 1 ☐ yes 2 ☐ no other autoimmune disease, specify: _____
    aa. 1 ☐ yes 2 ☐ no other, specify: _____
    bb. 1 ☐ yes 2 ☐ no unknown

14. Does the recipient have a history of smoking cigarettes?
    1 ☐ yes →
    2 ☐ no
    3 ☐ unknown

15. Has the recipient smoked cigarettes within the past year?
    1 ☐ yes
    2 ☐ no
    3 ☐ unknown

16. Has the recipient smoked cigarettes prior to but not during the past year?
    1 ☐ yes
    2 ☐ no
    3 ☐ unknown

Organ Function Prior To Conditioning

Provide values for recipient's liver function just prior to conditioning:

		Date tested: Month	Day	Year	What is the upper limit of normal for your institution?
17. AST (SGOT):	☐☐☐ U/L	18. ☐☐	☐☐	2 0 ☐☐	19. ☐☐☐ U/L
20. Serum creatinine:	☐☐☐.☐ 1 ☐ mg/dL 2 ☐ µmol/L	21. ☐☐	☐☐	2 0 ☐☐	22. ☐☐☐.☐ 1 ☐ mg/dL 2 ☐ µmol/L
23. Total serum bilirubin:	☐☐☐.☐ 1 ☐ mg/dL 2 ☐ µmol/L	24. ☐☐	☐☐	2 0 ☐☐	25. ☐☐☐.☐ 1 ☐ mg/dL 2 ☐ µmol/L
26. LDH:	☐☐☐☐ U/L	27. ☐☐	☐☐	2 0 ☐☐	28. ☐☐☐☐ U/L

Recipient NMDP ID: [ ][ ][ ] - [ ][ ][ ] - [ ]

Recipient Last Name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

29. Did the recipient have a history of clinically significant fungal infection (documented or suspected) at any time prior to conditioning for transplant?

1 ☐ yes →
2 ☐ no

30. Did the recipient have an active fungal infection within 2 weeks prior to conditioning?

1 ☐ yes
2 ☐ no

31. Select organism from list below. If more than one organism is documented or suspected, copy this page and complete a separate form for each organism.

F [ ][ ] If F15, specify fungus: _____

Commonly Reported Fungal Organisms

Fungal Infections

F1	Candida albicans	F7	Aspergillus flavus	F13	Mucormycosis (zygomycetes, Rhizopus)
F2	Candida krusei	F8	Aspergillus fumigatus	F14	Yeast, not otherwise specified
F3	Candida parasilosis	F9	Aspergillus niger	F15	Other fungus, specify above
F4	Candida tropicalis	F10	Aspergillus, not otherwise specified	F16	Suspected fungal infection
F5	Torulopsis glabrata (a subspecies of candida)	F11	Cryptococcus species		
F6	Candida, not otherwise specified	F12	Fusarium species		

32. Date of onset: [ ][ ] Month [ ][ ] Day [2][0][ ][ ] Year

33. Select site(s) from list. If more than one site was involved, list one site of infection in the first set of boxes, second site in the second set.

[ ][ ] First [ ][ ] Second

Common Sites of Infection

01	Blood only, not otherwise specified
02	Disseminated – generalized, isolated at 3 or more distinct sites
	Central Nervous System
03	Brain
04	Spinal cord
05	Meninges and CSF
06	Central nervous system unspecified
	Gastrointestinal Tract
07	Lips
08	Tongue, oral cavity and oro-pharynx
09	Esophagus
10	Stomach
11	Gallbladder and biliary tree (not Hepatitis), pancreas
12	Small intestine
13	Large intestine
14	Feces/stool
15	Peritoneum
16	Liver
17	Gastrointestinal tract unspecified
	Respiratory Tract
18	Upper airway and nasopharynx
19	Laryngitis/larynx
20	Lower respiratory tract (lung)
21	Pleural cavity, pleural fluid
22	Sinuses
23	Respiratory tract unspecified
	Gentio-Urinary Tract
24	Kidneys, renal pelvis, ureters and bladder
25	Prostate
26	Testes
27	Fallopian tubes, uterus, cervix
28	Vagina
29	Genito-urinary tract unspecified
	Skin
30	Genital area
31	Cellulitis
32	Herpes zoster
33	Rash, pustules or abscesses not typical of any of the above
34	Skin unspecified
	Other
35	Central venous catheter, not otherwise specified
36	Woundsite or catheter tip
37	Eyes
38	Ears
39	Joints
40	Bone marrow
41	Bone cortex (osteomyelitis)
42	Muscle (excluding cardiac)
43	Cardiac (endocardium, myocardium, pericardium)
44	Lymph nodes
45	Spleen
46	Other unspecified

Testing for serological evidence of prior viral exposure / infection

34. HTLV1	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
35. Cytomegalovirus antibody	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
36. Epstein-Barr antibody	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
37. Hepatitis B surface and/or core antibody	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
38. Hepatitis B surface antigen	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
39. Hepatitis C antibody	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
40. Hepatitis A antibody	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested
41. HIV 5 ☐ confidential	1 ☐ positive	2 ☐ negative	3 ☐ inconclusive	4 ☐ not tested

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Pre-Transplant Conditioning

42. Date pre-transplant conditioning began: ☐☐ Month ☐☐ Day 20☐☐ Year

43. Height at initiation of pre-transplant conditioning (nearest centimeter without shoes): ☐☐☐ cm

44. Weight at initiation of pre-transplant conditioning (nearest kilogram): ☐☐☐ kg

45. Was high-dose therapy (conditioning) given?
- 1 ☐ yes →
- 2 ☐ no

46. Indicate the protocol requirements for administering conditioning agents to the recipient.
- 1 ☐ all conditioning agents given as outpatient
- 2 ☐ some, but not all, agents given as inpatient
- 3 ☐ all agents given as inpatient

47. Was irradiation performed as part of the pre-transplant conditioning, or given within 4 days of conditioning regimen?
- 1 ☐ yes →
- 2 ☐ no → **Cont. with 67**

48. What was the radiation field?
- 1 ☐ total body →
  - 49. Total dose: ☐☐☐☐ cGy
  - 50. Starting date: ☐☐ Month ☐☐ Day 20☐☐ Year
  - 51. Was radiation fractionated?
    - 1 ☐ yes →
      - 52. Dose per fraction: ☐☐☐ cGy
      - 53. Number of days: ☐
      - 54. Total number of fractions: ☐☐
    - 2 ☐ no
- 2 ☐ total lymphoid or nodal regions →
  - 55. Total dose: ☐☐☐☐ cGy
  - 56. Starting date: ☐☐ Month ☐☐ Day 20☐☐ Year
  - 57. Was radiation fractionated?
    - 1 ☐ yes →
      - 58. Dose per fraction: ☐☐☐ cGy
      - 59. Number of days: ☐
      - 60. Total number of fractions: ☐☐
      - **Cont. with 67**
    - 2 ☐ no → **Cont. with 67**

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3 ☐ thoraco-abdominal region →

61. Total dose: ____ cGy

62. Starting date: ____ (Month) ____ (Day) 20__ (Year)

63. Was radiation fractionated?

1 ☐ yes →
2 ☐ no

64. Dose per fraction: ____ cGy

65. Number of days: ____

66. Total number of fractions: ____

Cont. with 67

Cont. with 67

67. Was additional radiation given to other sites within 14 days prior to start of pretransplant conditioning?

1 ☐ yes →
2 ☐ no

68. Was CNS irradiation performed?

1 ☐ yes →
2 ☐ no

69. Total dose: ____ cGy

70. Was gonadal irradiation performed?

1 ☐ yes →
2 ☐ no

71. Total dose: ____ cGy

72. Was splenic irradiation performed?

1 ☐ yes →
2 ☐ no

73. Total dose: ____ cGy

74. Was irradiation performed at the site of residual tumor?

1 ☐ yes →
2 ☐ no

75. Total dose: ____ cGy

76. Other site:

1 ☐ yes →
2 ☐ no

77. Specify site: _____

78. Total dose: ____ cGy

79. Date radiation started: ____ (Month) ____ (Day) 20__ (Year)

80. Was the recipient transplanted on a protocol with a conditioning regimen intended to be non-myeloablative?

1 ☐ yes
2 ☐ no

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

81. Were drugs given for pre-transplant conditioning?

1 ☐ yes → **Continue with drug list**

2 ☐ no → **Proceed to question 84**

Pre-Stem Cell Infusion	Total Dose (in mg)		Date Started Month	Day	Year	
a. ALG, ALS, ATG, ATS 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
b. busulfan (Myleran) 1 ☐ yes → 2 ☐ no	☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	→ 1 ☐ oral 2 ☐ IV
c. methylprednisolone 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	→ 1 ☐ oral 2 ☐ IV 3 ☐ both
d. prednisone 1 ☐ yes → 2 ☐ no	☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
e. other corticosteroid 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	→ Specify: _____
f. cyclophosphamide 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
g. cytarabine (Ara-C) 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
h. etoposide (VP-16) 1 ☐ yes → 2 ☐ no	☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
i. melphalan (L-Pam) 1 ☐ yes → 2 ☐ no	☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
j. thiotepa 1 ☐ yes → 2 ☐ no	☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
k. nitrosourea (BCNU, CCNU, carmustine, lomustine) 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
l. monoclonal antibody 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	→
m. intrathecal methotrexate 1 ☐ yes → 2 ☐ no	☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
n. intrathecal ARA-C 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
o. fludarabine 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
p. cladribine 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	
q. other 1 ☐ yes → 2 ☐ no	☐☐☐☐☐	mg	☐☐	☐☐	2 0 ☐☐	→ Specify: _____

82. Radionuclide-tagged monoclonal antibody, specify: _____
1 ☐ yes
2 ☐ no

83. Other monoclonal antibody, specify: _____
1 ☐ yes
2 ☐ no

Recipient NMDP ID: ☐☐☐-☐☐☐-☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Marrow Transplant Maneuver

Questions 84–98 are for marrow only. For peripheral blood stem cells, continue with question 102 and complete Form 580 – Filgrastim Mobilized PBSC Protocol, Transplant Center PBSC Product Analysis. For cord blood, continue with question 102 and complete Form 680 – Cord Blood Unit Supplement.

84. Date of receipt of marrow at your facility: ☐☐ Month ☐☐ Day 20☐☐ Year

85. Time (24-hour clock) at receipt of marrow: ☐☐ Hour : ☐☐ Minute
1 ☐ standard time
2 ☐ daylight savings time

86. Storage temperature during transport: 1 ☐ Refrigerated at 1–8°C 2 ☐ Room temperature

87. Nucleated cell count of the marrow before processing (uncorrected cell count): ☐☐.☐ x 10^6/mL

88. Total volume of marrow before processing: ☐☐☐☐.☐ mL

89. Was the marrow manipulated at your facility prior to transplant?
1 ☐ yes →
2 ☐ no

90. Specify the reason the marrow was manipulated:
1 ☐ volume reduction only
2 ☐ plasma depleted only
3 ☐ ABO incompatibility only
4 ☐ GVHD prophylaxis (T-cell depleted only) →

91. Specify method used:
1 ☐ antibody + complement →
2 ☐ antibody + toxin →
3 ☐ antibody affinity column →
4 ☐ antibody coated plates →
5 ☐ soybean lectin only
6 ☐ sheep red blood cell rosetting only
7 ☐ soybean lectin and sheep red blood cell rosetting
8 ☐ elutriation
9 ☐ immunomagnetic beads
10 ☐ soybean lectin and antibody coated plates
11 ☐ other, specify: _____

92. Specify antibody:

a. anti CD2	1 ☐ yes	2 ☐ no
b. anti CD3	1 ☐ yes	2 ☐ no
c. anti CD4	1 ☐ yes	2 ☐ no
d. anti CD5	1 ☐ yes	2 ☐ no
e. anti CD6	1 ☐ yes	2 ☐ no
f. anti CD7	1 ☐ yes	2 ☐ no
g. anti CD8	1 ☐ yes	2 ☐ no
h. anti CD34	1 ☐ yes	2 ☐ no
i. other, specify: _____	1 ☐ yes	2 ☐ no
j. no antibodies used	☐	

93. Time (24-hour clock) at start of infusion: ☐☐ Hour : ☐☐ Minute
1 ☐ standard time
2 ☐ daylight savings time

94. Total volume of marrow infused on the day of transplant: ☐☐☐☐.☐ mL

95. Cell count of infused marrow (uncorrected cell count): ☐☐☐.☐ x 10^6 / mL

Recipient NMDP ID: ☐☐☐ - ☐☐☐ - ☐ Recipient Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

96. Total CD34+ cells/kg infused: ☐☐☐ . ☐ x 10^6/kg ☐ not tested

97. Total cell viability: ☐☐ %

98. What was the method of testing cell viability?
- 1 ☐ trypan blue
- 2 ☐ propidium iodide
- 3 ☐ other method, specify: _____

99. Was a fraction of the collected marrow cryopreserved for back-up infusion?
- 1 ☐ yes →
- 2 ☐ no

100. Total volume of cryopreserved marrow: ☐☐☐ . ☐ mL

101. Nucleated cell count of cryopreserved marrow: ☐☐☐ . ☐ x 10^6 / mL

102. Was this the first transplant for this recipient?
- 1 ☐ yes
- 2 ☐ no →

103. Specify the number of prior transplants: ☐☐

104. What was (were) the prior stem cell source(s)?
- a. 1 ☐ yes 2 ☐ no autologous
- b. 1 ☐ yes 2 ☐ no allogeneic, related
- c. 1 ☐ yes 2 ☐ no allogeneic, related
- d. 1 ☐ yes 2 ☐ no allogeneic
- e. 1 ☐ yes 2 ☐ no syngeneic

105. Date of the last transplant (transplant just before current transplant): ☐☐ Month ☐☐ Day ☐☐☐☐ Year

106. Reason for current transplant:
- 1 ☐ no engraftment
- 2 ☐ partial engraftment
- 3 ☐ graft failure/rejection after achieving initial engraftment
- 4 ☐ persistent malignancy
- 5 ☐ recurrent malignancy →
- 6 ☐ secondary malignancy
- 7 ☐ planned second transplant, per protocol
- 8 ☐ other, specify: _____

107. Date of relapse: ☐☐ Month ☐☐ Day 2 0 ☐☐ Year

Socioeconomic Information

108. Is the recipient an adult (18 years of age or older) or emancipated minor?
- 1 ☐ yes →
- 2 ☐ no

109. Specify recipient's marital status:
- 1 ☐ single, never married
- 2 ☐ married
- 3 ☐ separated
- 4 ☐ divorced
- 5 ☐ widowed
- 6 ☐ unknown

Recipient NMDP ID: | | | | - | | | | - | | Recipient Last Name: | | | | | | | | | | | | | | | | |

110. Specify recipient's highest completed educational level:
- 1 ☐ grade 1–8
- 2 ☐ grade 9–11
- 3 ☐ high school graduate or equivalent (GED)
- 4 ☐ some college
- 5 ☐ junior college degree (e.g., associate's degree)
- 6 ☐ undergraduate degree (e.g., bachelor's degree)
- 7 ☐ some post-graduate work
- 8 ☐ advanced degree (e.g., master's degree / doctorate)
- 9 ☐ unknown

111. Specify the category which best describes the recipient's occupation:
If the recipient is not currently employed, check the box which best describes his/her last job.
- 1 ☐ professional, technical, or related occupation (e.g., teacher/professor, nurse/physician, lawyer, engineer)
- 2 ☐ manager, administrator, or proprietor (e.g., sales manager, real estate agent, postmaster)
- 3 ☐ clerical or related occupation (e.g., secretary, clerk, mail carrier)
- 4 ☐ sales occupation (e.g., sales associate, demonstrator, agent, broker)
- 5 ☐ service occupation (e.g., police officer, cook, hairdresser)
- 6 ☐ skilled craft or related occupation (e.g., carpenter, repair technician, telephone line worker)
- 7 ☐ equipment / vehicle operator or related occupation (e.g., driver, railroad brakeman, sewer worker)
- 8 ☐ laborer (e.g., helper, longshoreman, warehouse worker)
- 9 ☐ farmer (e.g., owner, manager, operator, tenant)
- 10 ☐ member of the military
- 11 ☐ homemaker
- 12 ☐ unknown
- 13 ☐ other, specify: _____

Questions 112–114 are for legal residents of the United States only. If the recipient is not a legal resident of the U.S., proceed to question 115.

112. Specify recipient's type of health insurance *(check all that apply)*:
- a. 1 ☐ yes 2 ☐ no no insurance
- b. 1 ☐ yes 2 ☐ no Medicaid
- c. 1 ☐ yes 2 ☐ no Medicare
- d. 1 ☐ yes 2 ☐ no disability insurance
- e. 1 ☐ yes 2 ☐ no health management organization (HMO)
- f. 1 ☐ yes 2 ☐ no individual health insurance
- g. 1 ☐ yes 2 ☐ no group health insurance
- h. 1 ☐ yes 2 ☐ no Veteran's Administration (VA) / military
- i. 1 ☐ yes 2 ☐ no other, specify: _____
- j. 1 ☐ yes 2 ☐ no unknown

Confidential Socioeconomic Information

113. Specify type of fee reimbursement:
- 1 ☐ fee-for-service
- 2 ☐ capitation
- 3 ☐ unknown
- 4 ☐ other, specify: _____

Recipient NMDP ID: ___ - ___ - ___ Recipient Last Name: _____

114. Specify recipient's combined household gross annual income:
Include earnings by all family members living in the household, before taxes.
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
10 ☐ unknown

115. Has the recipient signed an IRB-approved consent form to donate research blood samples?
1 ☐ yes → 116. Date form was signed: ___ (Month) ___ (Day) 20___ (Year)
2 ☐ no

117. Has the recipient signed an IRB-approved consent form for submitting research data to the NMDP?
1 ☐ yes → 118. Date form was signed: ___ (Month) ___ (Day) 20___ (Year)
2 ☐ no

119. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

If multiple cord blood units were infused, record each of the Cord Blood Unit identification numbers below: (NMDP or non-NMDP)

Cord Blood Unit NMDP ID: ____ - ____ - ___
Cord Blood Unit NMDP ID: ____ - ____ - ___
Cord Blood Unit NMDP ID: ____ - ____ - ___
Cord Blood Unit NMDP ID: ____ - ____ - ___
Cord Blood Unit NMDP ID: ____ - ____ - ___
Cord Blood Unit non-NMDP: _____
Cord Blood Unit non-NMDP: _____
Cord Blood Unit non-NMDP: _____