

CORE FORM

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:

Registry: IBMTR ABMTR (circle one)

Date of report:

Month Day Year

IBMTR



International Bone Marrow
Transplant Registry

Series 095 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: 414-266-8471

ABMTR



Antileukemic Blood & Marrow
Transplant Registry

Demographics

* If this is a report of a second (or subsequent) transplant check here ☐ and go to Q.20

1. Institutional protocol number (if applicable):

2. Was patient enrolled in cooperative group (eg. CALGB, CCSG, EBMT, ECOG, EORTC, MRC, NSABP, POG, SWOG, etc.) study at any time or reported to the NMDP or EBMT? (include transplant and non-transplant studies)

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

Study 1: 3. Group _____ 4. Study No. _____ 5. Patient No. _____

Study 2: 6. Group _____ 7. Study No. _____ 8. Patient No. _____

Study 3: 9. Group _____ 10. Study No. _____ 11. Patient No. _____

12. Sex: 1 ☐ Male 2 ☐ Female

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

Caucasian/White

- 11 ☐ European or Western Russia
12 ☐ Middle East or
North Coast of Africa
10 ☐ White,
not otherwise specified

Black

- 21 ☐ African American
22 ☐ African Black (both
parents born in Africa)
23 ☐ Caribbean Black
24 ☐ South or
Central American Black
20 ☐ Black,
not otherwise specified

Asian/Pacific Islander

- 31 ☐ Asian Indian
32 ☐ Filipino
33 ☐ Hawaiian (Polynesian)
34 ☐ Japanese
35 ☐ Korean
36 ☐ Northern Chinese
37 ☐ Southeast Asian/
Southern Chinese
30 ☐ Oriental,
not otherwise specified

Hispanic

- 41 ☐ Caribbean Hispanic
42 ☐ Mexican or Southwestern
USA Hispanic

- 43 ☐ South or Central
American Hispanic
40 ☐ Hispanic,
not otherwise specified

Native American

- 51 ☐ Native Alaskan/
Eskimo/Aleut
52 ☐ American Indian
50 ☐ Native American,
not otherwise specified

Other

- 90 ☐ Other, specify:
88 ☐ Unknown

14. Date of birth:

Month Day Year

TEAM IUBMID

Disease

15. What was the primary disease for which transplant was performed?
(Appropriate Insert must be submitted with this form)

10 ☐ Acute
myelogenous
leukemia
(AML or ANLL)

- 11 ☐ M1, myeloblastic
12 ☐ M2, myelocytic
13 ☐ M3, promyelocytic
(APML, APL)
14 ☐ M4, myelomonocytic
15 ☐ M5, monocytic
16 ☐ M6, erythroblastic
17 ☐ M7, megakaryoblastic
18 ☐ Granulocytic sarcoma
19 ☐ Other, specify:

10 ☐ Unknown

Complete Insert I and continue
with Question 17 on Page 5

20 ☐ Acute
lymphoblastic
leukemia (ALL)

- 21 ☐ Mature B-cell (L3)
22 ☐ T-cell
23 ☐ Null cell (early Pre-B)
24 ☐ cALLa (includes Pre-B)
29 ☐ Other, specify:

20 ☐ Unknown

Complete Insert II and continue
with Question 17 on Page 5

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 -
49 ☐ Other, specify:

40 ☐ Ph¹ unknown;
BCR/ABL unknown

Complete Insert III and continue
with Question 17 on Page 5

30 ☐ Other
leukemia

34 ☐ Chronic lymphocytic leukemia (CLL)

Complete Insert IV and continue
with Question 17 on Page 5

- 31 ☐ Acute undifferentiated leukemia
32 ☐ Biphenotypic, bilineage or
hybrid leukemia
33 ☐ Acute mast cell leukemia
35 ☐ Hairy cell leukemia
36 ☐ Juvenile CML (no evidence of
Philadelphia chromosome or
BCR/ABL)
37 ☐ Polymphocytic leukemia (PLL)
38 ☐ M0, stem cell
39 ☐ Other, specify:

30 ☐ Unknown

Continue with Question 16
on Page 5

50 ☐ Myelodysplastic/
myeloprolifer-
ative disorders
(please classify
all preleukemias)

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

- 51 ☐ Refractory anemia (RA)
52 ☐ Refractory anemia with
excess blasts (RAEB)
53 ☐ Refractory anemia with
excess blasts in transfor-
mation (RAEBT)
54 ☐ Chronic myelomonocytic
leukemia (CMML)
55 ☐ Acquired idiopathic
sideroblastic anemia (RARS)
56 ☐ Paroxysmal nocturnal
hemoglobinuria (PNH)
57 ☐ Polycythemia vera
58 ☐ Essential or primary
thrombocythemia
59 ☐ Myelofibrosis with
myeloid metaplasia
60 ☐ Other myelofibrosis or
myelosclerosis
69 ☐ Other myelodysplasia or
myeloproliferative
disorder, specify:

50 ☐ Unknown

Complete Insert V and continue
with Question 17 on Page 5

100 ☐ Non-Hodgkin lymphoma

- 101 ☐ Small cell lymphocytic
 102 ☐ Follicular, predominantly small cleaved cell
 103 ☐ Follicular, mixed, small cleaved and large cell
 104 ☐ Follicular, predominantly large cell
 105 ☐ Diffuse, small cleaved cell
 106 ☐ Diffuse, mixed, small and large cell
 107 ☐ Diffuse, large cell
 108 ☐ Large cell, immunoblastic
 109 ☐ Lymphoblastic
 110 ☐ Small noncleaved cell, unclassified
 111 ☐ Small noncleaved cell, Burkitt
 112 ☐ Small noncleaved cell, non-Burkitt
 113 ☐ Mycosis fungoides
 114 ☐ Histiocytic
 115 ☐ Mantle cell/intermediate differentiation
 116 ☐ Composite, specify: _____
 117 ☐ Large cell anaplastic lymphoma, Ki1 positive
 118 ☐ Primary CNS lymphoma
 119 ☐ Other non-Hodgkin lymphoma, specify: _____
 100 ☐ Non-Hodgkin lymphoma, unknown

Complete Insert VI and continue with Question 17 on Page 5

150 ☐ Hodgkin lymphoma

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

Complete Insert VI and continue with Question 17 on Page 5

170 ☐ Multiple myeloma/Plasma cell disorder

- 171 ☐ Multiple myeloma
 172 ☐ Plasma cell leukemia
 173 ☐ Waldenstrom macroglobulinemia
 174 ☐ Amyloidosis
 175 ☐ Solitary plasmacytoma
 179 ☐ Other, specify: _____

Continue with Question 16 on Page 5

200 ☐ Other malignancies

250 ☐ Breast cancer

Complete Insert VIII and continue with Question 17 on Page 5

- 201 ☐ Head & neck cancer
 202 ☐ Lung cancer, small cell
 203 ☐ Lung cancer, non-small cell
 239 ☐ Lung, not otherwise specified
 204 ☐ Mediastinal neoplasm, specify: _____
 205 ☐ GI tract cancer
 206 ☐ Pancreatic cancer
 207 ☐ Hepatobiliary cancer
 208 ☐ Kidney & urinary tract cancer
 209 ☐ Prostate cancer
 210 ☐ Testicular cancer
 211 ☐ External genitalia cancer
 212 ☐ Cervical cancer
 213 ☐ Uterine cancer
 214 ☐ Ovarian (epithelial) cancer
 215 ☐ Vaginal cancer
 216 ☐ Sarcoma unspecified
 217 ☐ Soft tissue sarcoma
 218 ☐ Bone sarcoma (not Ewing)
 219 ☐ Melanoma
 220 ☐ Central nervous system tumor
 221 ☐ Wilms tumor
 222 ☐ Neuroblastoma
 223 ☐ Retinoblastoma
 224 ☐ Ewing sarcoma
 269 ☐ Other malignancy, specify: _____

Continue with Question 16 on Page 5

300 ☐ Severe aplastic anemia

- 301 ☐ Idiopathic
 302 ☐ Secondary to hepatitis
 303 ☐ Secondary to toxin/other drug
 304 ☐ Amegakaryocytosis (not congenital)
 309 ☐ Other, specify: _____

Complete Insert IX and continue with Question 17 on Page 5

310 ☐ Inherited abnormalities of erythrocyte differentiation or function

(If patient has developed leukemia, complete Insert for appropriate leukemia diagnosis)

311 ☐ Fanconi anemia

Complete Insert X and continue with Question 17 on Page 5

- 312 ☐ Diamond-Blackfan anemia (pure red cell aplasia)
 319 ☐ Other, specify: _____

Complete Insert IX and continue with Question 17 on Page 5

TEAM IUBMID

310 ☐ Inherited abnormalities of erythrocyte differentiation or function, continued

- 350 ☐ Thalassemia major (β thalassemia), unspecified
351 ☐ Type A Thalassemia major
352 ☐ Type B+ Thalassemia major
353 ☐ Type B0 Thalassemia major
354 ☐ Type BE Thalassemia major
355 ☐ Sickle Thalassemia major
356 ☐ Sickle cell anemia
359 ☐ Other hemoglobinopathy, specify: _____

310 ☐ Unknown

Complete Insert XI and continue with Question 17 on Page 5

400 ☐ SCID and other 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
419 ☐ SCID other, specify: _____

- 451 ☐ Ataxia telangiectasia
452 ☐ HIV infection
454 ☐ DiGeorge anomaly
455 ☐ Chronic granulomatous disease
456 ☐ Chediak-Higashi syndrome
457 ☐ Common variable immunodeficiency

- 458 ☐ X-linked lymphoproliferative syndrome
459 ☐ Leukocyte adhesion deficiencies, including GP180, CD-18, LFA and WBC adhesion deficiencies

- 460 ☐ Kostmann agranulocytosis (congenital neutropenia)
461 ☐ Neutrophil actin deficiency
462 ☐ Cartilage-hair hypoplasia
470 ☐ Combined immunodeficiency disease (CID), unspecified

- 474 ☐ CID other, specify: _____
479 ☐ Other immunodeficiencies, specify: _____

Complete Insert XII and continue with Question 17 on Page 5

- 453 ☐ Wiskott Aldrich syndrome

Complete Insert XIII and continue with Question 17 on Page 5

500 ☐ Inherited abnormalities of platelets

- 501 ☐ Amegakaryocytosis/congenital thrombocytopenia
502 ☐ Glanzmann thrombasthenia
509 ☐ Other, specify: _____

Continue with Question 16 on Page 5

520 ☐ Inherited disorders of metabolism

- 521 ☐ Osteopetrosis (malignant infantile osteopetrosis)

Complete Insert XV and continue with Question 17 on Page 5

- 522 ☐ Lesch-Nyhan Mucopolysaccharidosis

- 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, not otherwise specified

Mucopolipidoses

- 541 ☐ Gaucher disease
542 ☐ Metachromatic leukodystrophy
543 ☐ Adrenoleukodystrophy
544 ☐ Krabbe disease (globoid leukodystrophy)
545 ☐ Neiman-Pick disease
546 ☐ I-cell disease
547 ☐ Wolman disease
548 ☐ Glucose storage disease
549 ☐ Lysosomal storage disease
559 ☐ Other mucopolipidoses, specify: _____

- 540 ☐ Mucopolipidoses, not otherwise specified
529 ☐ Other specific inherited metabolic disorders, specify: _____

520 ☐ Unknown

Complete Insert XIV and continue with Question 17 on Page 5

570 ☐ Histiocytic disorders

- 571 ☐ Familial erythrophagocytic lymphohistiocytosis (FEL, Familial hemophagocytic lymphohistiocytosis)

- 572 ☐ Histiocytosis-X
573 ☐ Hemophagocytosis
574 ☐ Malignant histiocytosis
579 ☐ Other, specify: _____

570 ☐ Unknown

Continue with Question 16 on Page 5

900 ☐ Other

Specify: _____
Continue with Question 16 on Page 5

TEAM IUBMID **Clinical Status of Patient Prior to Conditioning**

16. Date of diagnosis of primary disease:
(complete only if a disease-specific
Insert is not required) Month Day Year

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

- | | | | |
|--|--|---|-------------------------------------|
| 1 ☐ A Positive | 5 ☐ A Negative | 9 ☐ A Rh unknown | 88 ☐ Unknown |
| 2 ☐ B Positive | 6 ☐ B Negative | 10 ☐ B Rh unknown | |
| 3 ☐ AB Positive | 7 ☐ AB Negative | 11 ☐ AB Rh unknown | |
| 4 ☐ O Positive | 8 ☐ O Negative | 12 ☐ O Rh unknown | |

18. Has patient ever been pregnant?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

7 ☐ Not applicable (patient is male, or a female child)

19. Number of pregnancies:

20. Did patient receive blood transfusions at any time prior to conditioning?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

21. Give number (best estimate) of donor exposures:

- | | |
|------------------------------------|------------------------------------|
| 1 ☐ 1 - 5 | 5 ☐ 31 - 40 |
| 2 ☐ 6 - 10 | 6 ☐ 41 - 50 |
| 3 ☐ 11 - 20 | 7 ☐ > 50 |
| 4 ☐ 21 - 30 | 8 ☐ Unknown |

22. What was the functional status of patient prior to conditioning?

If the 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 $\geq$ 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 restriction 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

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

1 ☐ Yes0 ☐ No

What were the diagnoses?

Yes No24. 1 ☐ 0 ☐ Significant hemorrhage (e.g. CNS or GI), specify site(s):
_____Cardiovascular25. 1 ☐ 0 ☐ Coronary artery disease26. 1 ☐ 0 ☐ Hypertension27. 1 ☐ 0 ☐ Other cardiac disease, specify: _____Endocrine28. 1 ☐ 0 ☐ Diabetes mellitus29. 1 ☐ 0 ☐ Thyroid disease30. 1 ☐ 0 ☐ Other endocrine disease, specify: _____CNS31. 1 ☐ 0 ☐ Seizure disorder32. 1 ☐ 0 ☐ Other CNS disease, specify: _____Pulmonary33. 1 ☐ 0 ☐ Asthma34. 1 ☐ 0 ☐ Other pulmonary disease, specify: _____35. 1 ☐ 0 ☐ Genitourinary disease, specify: _____36. 1 ☐ 0 ☐ Gastrointestinal disease, specify: _____37. 1 ☐ 0 ☐ Hematologic disease, specify: _____Chromosomal38. 1 ☐ 0 ☐ Fanconi anemia39. 1 ☐ 0 ☐ Down syndrome40. 1 ☐ 0 ☐ Other chromosomal disorders, specify: _____41. 1 ☐ 0 ☐ History of other malignancy, specify: _____42. 1 ☐ 0 ☐ Neonatal GVHDAutoimmune disease43. 1 ☐ 0 ☐ Rheumatoid arthritis44. 1 ☐ 0 ☐ Systemic lupus erythematosus45. 1 ☐ 0 ☐ Multiple sclerosis46. 1 ☐ 0 ☐ Polyarteritis nodosa47. 1 ☐ 0 ☐ Psoriasis48. 1 ☐ 0 ☐ Other autoimmune disease, specify: _____49. 1 ☐ 0 ☐ Other, specify: _____

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Organ Function Prior to Conditioning

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

		Date tested:			
		Month	Day	Year	What is the upper limit of normal for your institution?
50. AST (SGOT)	. U/L	51.			52. . U/L
53. ALT (SGPT)	. U/L	54.			55. . U/L
56. Total serum bilirubin	.	58.			59. .

57. Unit of measurement for bilirubin:
1 ☐ mg/dL 2 ☐ μ mol/L

60. LDH . U/L

61.

62. . U/L

63. Did patient have known clinical liver disease (eg. viral hepatitis) at any time prior to conditioning?

- 1 ☐ Yes
0 ☐ No

	Yes	No	Unknown	
64. 1 ☐ 0 ☐ 8 ☐	☐	☐	☐	Hepatitis B
65. 1 ☐ 0 ☐ 8 ☐	☐	☐	☐	Hepatitis A
66. 1 ☐ 0 ☐ 8 ☐	☐	☐	☐	Hepatitis C
67. 1 ☐ 0 ☐ 8 ☐	☐	☐	☐	Drug toxicity
68. 1 ☐ 0 ☐ 8 ☐	☐	☐	☐	Other, specify: _____
69. Date of onset:				☐ Date Unknown
		Month	Year	

70. What was patient's serum creatinine prior to conditioning?

.

72.

Month Day Year

71. Unit of measurement for creatinine:
1 ☐ mg/dL 2 ☐ μ mol/L

73. Patient smokes cigarettes, or has in the past:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

74. Average number of packs per day: .

75. Number of years:

TEAM IUBMID 76. Was clinically important infection(s) present or being treated within one week prior to conditioning?

Note: Report later infections on page 30 of this report.

1 ☐ Yes0 ☐ No

Select site and organism from lists shown on the next page and place number in the appropriate spaces. If more than one site or organism were involved, list one site of infection and organism on the first line, second site and/or organism on second line.

		Site	Organism
77. ☐ Bacterial			
<u>Typical</u>	First	78.	79.
	Second	80.	81.

Atypical

First	83.	84.
Second	85.	86.

87. Other atypical bacterium, specify:

88. ☐ Fungal	First	89.	90.
	Second	91.	92.

93. Other fungus, specify:

94. ☐ Viral	First	95.	96.
	Second	97.	98.

99. Other virus, specify:

100. ☐ Parasitic	First	101.	102.
	Second	103.	104.

105. Other parasite, specify:

106. ☐ No organism identified	First	107.	108.
	Second	109.	110.

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Codes for Common Sites of Infection

- | | |
|--|---|
| 01 Blood/buffy coat | 40 <u>Genito-Urinary Tract unspecified</u> |
| 02 Disseminated – generalized,
isolated at 3 or more distinct sites | 41 Kidneys, renal pelvis, ureters and bladder |
| 03 <u>Central Nervous System unspecified</u> | 42 Prostate |
| 04 Brain | 43 Testes |
| 05 Spinal cord | 44 Fallopian tubes, uterus, cervix |
| 06 Meninges and CSF | 45 Vagina |
| 10 <u>Gastrointestinal Tract unspecified</u> | 50 <u>Skin unspecified</u> |
| 11 Lips | 51 Genital area |
| 12 Tongue, oral cavity and oro-pharynx | 52 Cellulitis |
| 13 Esophagus | 53 Herpes Zoster |
| 14 Stomach | 54 Rash, pustules or abscesses not typical
of any of the above |
| 15 Gallbladder and biliary tree (not hepatitis), pancreas | 60 Central venous catheter, not otherwise specified |
| 16 Small intestine | 61 Catheter insertion site |
| 17 Large intestine | 62 Catheter tip |
| 18 Feces/stool | 70 Eyes |
| 19 Peritoneum | 75 Ear |
| 20 Liver | 80 <u>Other unspecified</u> |
| 30 <u>Respiratory unspecified</u> | 81 Joints |
| 31 Upper airway and nasopharynx | 82 Bone marrow |
| 32 Laryngitis/larynx | 83 Bone cortex (osteomyelitis) |
| 33 Lower respiratory tract (lung) | 84 Muscle (excluding cardiac) |
| 34 Pleural cavity, pleural fluid | 85 Cardiac (endocardium, myocardium, pericardium) |
| 35 Sinuses | 86 Lymph nodes |
| | 87 Spleen |

Codes for Commonly Reported Organisms

1. Bacteria

(Indicate code for atypical bacteria;
list bacterium for non-atypical bacteria.)

- 100 Atypical bacteria, not otherwise specified
- 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

2. Fungal Infections

- 200 Candida, not otherwise specified
- 201 Candida albicans
- 202 Candida krusei
- 203 Candida parapsilosis
- 204 Candida tropicalis
- 205 Torulopsis glabrata (a subspecies of candida)
- 209 Candida, other
- 210 Aspergillus, not otherwise specified
- 211 Aspergillus flavus
- 212 Aspergillus fumigatus
- 213 Aspergillus niger
- 219 Aspergillus, other
- 220 Cryptococcus species
- 230 Fusarium species
- 240 Mucormycosis (zygomycetes, rhizopus)
- 250 Yeast, not otherwise specified
- 259 Other fungus, specify

3. 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

4. Parasite Infections

- 401 Pneumocystis (PCP)
- 402 Toxoplasma
- 403 Giardia
- 404 Cryptosporidium
- 409 Other parasite (amebiasis, echinococcal cyst,
trichomonas – either vaginal or gingivitis), specify

5. Other Infections

- 509 No organism identified

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112. Did patient have a history of clinically important fungal infection at any time prior to conditioning for transplant?

- 1 ☐ Yes
0 ☐ No

113. Date of onset:

Month Year

114. Select organism from list on previous page:

If other, specify: _____

Select site(s) from list on previous page:

115.

116.

Other, specify: _____

Tests for Serological Evidence of Prior Viral Exposure / Infection

	Positive	Negative	Inconclusive	Not Tested
117. HTLV1 antibody	1 ☐	2 ☐	3 ☐	4 ☐
118. Toxoplasma antibody	1 ☐	2 ☐	3 ☐	4 ☐
119. Cytomegalovirus antibody	1 ☐	2 ☐	3 ☐	4 ☐
120. Epstein-Barr antibody	1 ☐	2 ☐	3 ☐	4 ☐
121. Hepatitis B surface and/or core antibody	1 ☐	2 ☐	3 ☐	4 ☐
122. Hepatitis B surface antigen	1 ☐	2 ☐	3 ☐	4 ☐
123. Hepatitis C antibody	1 ☐	2 ☐	3 ☐	4 ☐
124. Hepatitis A antibody	1 ☐	2 ☐	3 ☐	4 ☐
125. Human Immunodeficiency Virus (HIV) antibody	1 ☐	2 ☐	3 ☐	4 ☐

7 ☐ Not able to release information for HIV

High-Dose Therapy (Pretransplant Conditioning)

126. Was patient given high-dose therapy (conditioning) as an inpatient?

- 1 ☐ Yes
0 ☐ No, given as outpatient
7 ☐ No high dose therapy given

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

- 1 ☐ Yes
0 ☐ No

Please specify:

Yes No

128. 1 ☐ 0 ☐ Conventional private room
129. 1 ☐ 0 ☐ Laminar air flow room
130. 1 ☐ 0 ☐ HEPA filtered room
131. 1 ☐ 0 ☐ Positive pressure
132. 1 ☐ 0 ☐ Other, specify: _____

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

Month Day Year

134. Height at initiation of pretransplant conditioning (without shoes):

cm

135. Weight at initiation of pretransplant conditioning (without shoes):

kg

136. Was irradiation performed as part of the pretransplant conditioning regimen? 1 ☐ Yes 0 ☐ No Go to Q. 182

137. Source of x-ray therapy:

1 ☐ Linear accelerator 2 ☐ ⁶⁰Co 7 ☐ Other, specify: _____

138. Maximum energy: MV (million volts)

139. Calculated mid-line dose-rate during irradiation: cGy (rad)/min

What was the radiation field?

140. Total Body Radiation

1 ☐ Yes
0 ☐ No

141. Total dose: cGy

Prescription point:

Yes No

142. 1 ☐ 0 ☐ Midline umbilicus

143. 1 ☐ 0 ☐ Other, specify: _____

Patient orientation:

Yes No

144. 1 ☐ 0 ☐ AP/PA

145. 1 ☐ 0 ☐ Other, specify: _____

Method of dose verification:

Yes No

146. 1 ☐ 0 ☐ Phantom

147. 1 ☐ 0 ☐ Diodes on patient

148. 1 ☐ 0 ☐ Other, specify: _____

149. Starting date:
Month Day Year

150. Was radiation fractionated?

1 ☐ Yes
0 ☐ No
8 ☐ Unknown

151. Dose per fraction: cGy

152. Number of days:

153. Total number of fractions:

154. Was shielding used?

1 ☐ Yes
0 ☐ No
8 ☐ Unknown

Yes No

155. 1 ☐ 0 ☐ Lungs

156. 1 ☐ 0 ☐ Eyes

157. 1 ☐ 0 ☐ Liver

158. 1 ☐ 0 ☐ Kidney

159. 1 ☐ 0 ☐ Other, specify: _____

Radiation field data continued on next page

TEAM IUBMID 160. Total lymphoid or nodal regions 1 ☐ Yes0 ☐ No161. Total dose: cGy162. Starting date:

Month Day Year

163. Was radiation fractionated?

1 ☐ Yes0 ☐ No8 ☐ Unknown164. Dose per fraction: cGy165. Number of days: 166. Total number of fractions:

167. Thoraco-abdominal region

1 ☐ Yes0 ☐ No168. Total dose: cGy169. Starting date:

Month Day Year

170. Was radiation fractionated?

1 ☐ Yes0 ☐ No8 ☐ Unknown171. Dose per fraction: cGy172. Number of days: 173. Total number of fractions:

174. Other radiation field

1 ☐ Yes0 ☐ No

175. Specify field: _____

176. Total dose: cGy177. Starting date:

Month Day Year

178. Was radiation fractionated?

1 ☐ Yes0 ☐ No8 ☐ Unknown179. Dose per fraction: cGy180. Number of days: 181. Total number of fractions:

TEAM IUBMID

182. Was (additional) radiation given to other sites?

1 ☐ Yes
0 ☐ No

183. Was CNS irradiation performed?

1 ☐ Yes — 184. cGy
0 ☐ No Dose:

185. Date started:
Month Day Year

186. Was gonadal irradiation performed?

1 ☐ Yes — 187. cGy
0 ☐ No Dose:

188. Date started:
Month Day Year

189. Was splenic irradiation performed?

1 ☐ Yes — 190. cGy
0 ☐ No Dose:

191. Date started:
Month Day Year

192. Other site, specify: _____

1 ☐ Yes — 193. cGy
0 ☐ No Dose:

194. Date started:
Month Day Year

195. Were drugs given for pretransplant conditioning? 1 ☐ Yes 0 ☐ No — Go to Q. 361

196. Date started:
Month Day Year

	Drug Given		Total dose (in mg) pre-marrow infusion (not daily dose)	Number of doses	Continuous infusion		Number of days
	No	Yes			Yes	No	
197. ALG, ALS, ATG, ATS	0 ☐	1 ☐	198.	199.	200. 1 ☐ 0 ☐	201.	
202. Anthracycline	0 ☐ No 1 ☐ Yes						
203. Daunomycin	0 ☐	1 ☐	204.	205.	206. 1 ☐ 0 ☐	207.	
208. Doxorubicin (Adriamycin)	0 ☐	1 ☐	209.	210.	211. 1 ☐ 0 ☐	212.	
213. Idarubicin	0 ☐	1 ☐	214.	215.	216. 1 ☐ 0 ☐	217.	
218. Rubidazone	0 ☐	1 ☐	219.	220.	221. 1 ☐ 0 ☐	222.	
223. Other anthra- cycline, specify: _____	0 ☐	1 ☐	224.	225.	226. 1 ☐ 0 ☐	227.	
228. Bleomycin	0 ☐	1 ☐	229.	230.	231. 1 ☐ 0 ☐	232.	
233. Busulfan (myleran)	0 ☐	1 ☐	234.	235.	236. 1 ☐ 0 ☐	237.	
238. Carboplatin	0 ☐	1 ☐	239.	240.	241. 1 ☐ 0 ☐	242.	
243. Cisplatin	0 ☐	1 ☐	244.	245.	246. 1 ☐ 0 ☐	247.	

Continued on next page

TEAM IUBMID

	Drug Given		Total dose (in mg)	Number of doses	Continuous infusion	Number of days
	No	Yes	pre-marrow infusion			
248. Corticosteroids	☐ No ☐ Yes					
249. Methylprednisolone (Solumedrol)						
1 ☐ Yes	250. ☐ Oral ☐ IV		251.	252.	253. 1 ☐ 0 ☐	254.
0 ☐ No						
255. Prednisone	☐	☐	256.	257.	258. 1 ☐ 0 ☐	259.
260. Dexamethasone	☐	☐	261.	262.	263. 1 ☐ 0 ☐	264.
265. Other cortico-steroids, specify:	☐	☐	266.	267.	268. 1 ☐ 0 ☐	269.
270. Cyclophosphamide	☐	☐	271.	272.	273. 1 ☐ 0 ☐	274.
275. Cytarabine (Ara-C)	☐	☐	276.	277.	278. 1 ☐ 0 ☐	279.
280. Etoposide (VP16)	☐	☐	281.	282.	283. 1 ☐ 0 ☐	284.
285. Ifosfamide	☐	☐	286.	287.	288. 1 ☐ 0 ☐	289.
290. Intrathecal chemotherapy	☐ No ☐ Yes					
291. Cytarabine	☐	☐	292.	293.		294.
295. Methotrexate	☐	☐	296.	297.		298.
299. Other, specify:	☐	☐	300.	301.		302.
303. Melphalan (L-PAM)						
1 ☐ Yes	304. ☐ Oral ☐ IV		305.	306.	307. 1 ☐ 0 ☐	308.
0 ☐ No						
309. Mitoxantrone	☐	☐	310.	311.	312. 1 ☐ 0 ☐	313.
314. Monoclonal antibody	☐ No ☐ Yes					
315. Radionuclide-tagged Mab, specify:	☐	☐	316.	317.	318. 1 ☐ 0 ☐	319.
320. Campath	☐	☐	321.	322.	323. 1 ☐ 0 ☐	324.
325. Other Mab, specify:	☐	☐	326.	327.	328. 1 ☐ 0 ☐	329.

Continued on next page

TEAM IUBMID

	Drug Given		Total dose (in mg) pre-marrow infusion	Number of doses	Continuous infusion		Number of days
	No	Yes			Yes	No	
330. Nitrosourea	0 ☐ No 1 ☐ Yes						
331. BCNU	0 ☐	1 ☐	332.	333.	334. 1 ☐ 0 ☐		335.
336. CCNU	0 ☐	1 ☐	337.	338.	239. 1 ☐ 0 ☐		340.
341. Other nitrosourea, specify:	0 ☐	1 ☐	342.	343.	344. 1 ☐ 0 ☐		345.
Paclitaxel (Taxol)	0 ☐	1 ☐			1 ☐ 0 ☐		
346. Teniposide (VM26)	0 ☐	1 ☐	347.	348.	349. 1 ☐ 0 ☐		350.
351. Thiotepa	0 ☐	1 ☐	352.	353.	354. 1 ☐ 0 ☐		355.
356. Other, specify:	0 ☐	1 ☐	357.	358.	359. 1 ☐ 0 ☐		360.

361. Was this the first transplant for this recipient?

1 ☐ Yes
0 ☐ No

362. Is a second transplant planned as part of treatment protocol?

1 ☐ Yes
0 ☐ No

Go to Q. 384

363. Number of previous transplants recipient has had:

(if more than 1 previous transplant, photocopy Q.364-383 and answer for each previous transplant)

Continued on next page

TEAM IUBMID

364. Date of previous transplant:
Month Day Year

365. Graft type of previous transplant:

1 ☐ Autologous

Yes No

366. 1 ☐ 0 ☐ Bone marrow

367. 1 ☐ 0 ☐ Peripheral blood

368. 1 ☐ 0 ☐ Other, specify: _____

369. Was this transplant reported to the ABMTR – North America?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

ABMTR I.D.

2 ☐ Allogeneic,
unrelated
donor

370. Same donor as current transplant? 1 ☐ Yes 0 ☐ No

Yes No

371. 1 ☐ 0 ☐ Bone marrow

372. 1 ☐ 0 ☐ Peripheral blood

373. 1 ☐ 0 ☐ Cord blood

Yes No

374. 1 ☐ 0 ☐ Fetal tissue

375. 1 ☐ 0 ☐ Other, specify: _____

376. Was this transplant reported to the IBMTR?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

IBMTR I.D.

3 ☐ Allogeneic,
related donor

377. Same donor as current transplant? 1 ☐ Yes 0 ☐ No

Yes No

378. 1 ☐ 0 ☐ Bone marrow

379. 1 ☐ 0 ☐ Peripheral blood

Yes No

380. 1 ☐ 0 ☐ Cord blood

381. 1 ☐ 0 ☐ Other, specify: _____

382. Was this transplant reported to the IBMTR?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

IBMTR I.D.

383. Reason for re-transplant:

1 ☐ No engraftment

2 ☐ Partial engraftment

3 ☐ Graft failure/rejection

4 ☐ Persistent malignancy

5 ☐ Recurrent malignancy

6 ☐ Planned second transplant, per protocol

7 ☐ Other, specify: _____

384. What type of graft did patient receive for the current transplant?

1 ☐ Autologous

2 ☐ Allogeneic

3 ☐ Syngeneic

Complete INSERT
ALLOBM

385. From where were stem cells obtained?

1 ☐ Bone marrow — Complete INSERT AUTOBM

2 ☐ Blood — Complete INSERT AUTOPB

3 ☐ Bone marrow & Blood — Complete INSERTS AUTOBM & AUTOPB

TEAM IUBMID

Posttransplant Information

Provide information for first 100 days after transplant OR until start of conditioning (high-dose therapy) for second or subsequent transplant if started < 100 days after initial transplant OR until infusion of cells for second transplant without conditioning if done < 100 days after initial transplant OR until donor leukocyte infusion done to treat relapse, infection, or lymphoproliferative disorder or graft failure if done < 100 days after initial transplant OR until time of death if death occurred < 100 days after transplant. If this form is being completed more than 100 days after transplant, provide data to 100 days on this form. Provide data for course after 100 days on a follow-up form. **IF YOU HAVE ANY QUESTIONS ABOUT HOW TO COMPLETE THIS SECTION OF THE FORM, PLEASE CONTACT THE STATISTICAL CENTER.**

386. Date of last actual contact with patient to determine medical status for this report:
Month Day Year

387. Did patient die prior to day 100 after this transplant?

- 1 ☐ Yes – Answers to subsequent questions should reflect clinical status immediately prior to death
0 ☐ No – Answers to subsequent questions should reflect clinical status on day of actual contact for this follow-up examination (approximately 100 days posttransplant)

388. Did patient receive a subsequent blood or marrow infusion after the transplant for which this report is being completed? (other than peripheral blood leukocytes or T-lymphocytes from original allogeneic donor)

- 1 ☐ Yes
0 ☐ No

Answers to the following questions should reflect clinical status immediately prior to start of conditioning for subsequent infusion. A separate report covering the subsequent transplant must be submitted.

389. Date of subsequent infusion:
Month Day Year

390. Reason for subsequent infusion:

- 1 ☐ No engraftment
2 ☐ Partial engraftment
3 ☐ Late graft failure
4 ☐ Persistent malignancy
5 ☐ Relapse
6 ☐ Planned second transplant, per protocol
7 ☐ Other, specify: _____

391. Type of graft:

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

Donor:

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

Source of cells:

392. 1 ☐ Fresh
2 ☐ Cryopreserved

393. Check all that apply:

- 1 ☐ Yes 0 ☐ No Bone marrow
1 ☐ Yes 0 ☐ No Peripheral blood
1 ☐ Yes 0 ☐ No Cord blood
1 ☐ Yes 0 ☐ No Fetal tissue
1 ☐ Yes 0 ☐ No Other, specify: _____

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395. **Allografts only:** Has patient received an infusion of peripheral blood leukocytes or T-lymphocytes from the original donor?

1 ☐ Yes

0 ☐ No

396. Date first infusion given:

--	--

--	--

--	--

Month Day Year

397. Patient weight within 2 weeks of first infusion:

--	--

 kg

398. Total number of infusions:

--	--

399. Total dose of mononuclear cells given:

--	--	--

 .

--

 $\times 10^{10}$

400. Were cells manipulated prior to infusion?

1 ☐ Yes

0 ☐ No

401. Indicate method:

1 ☐ T-cell depletion

2 ☐ CD34 selection

7 ☐ Other, specify: _____

402. Indication for the infusion(s) of donor cells:

1 ☐ Prophylaxis against B-cell lymphoproliferative disorder (or viral infection)

2 ☐ Prophylaxis against relapse

3 ☐ Treatment of relapse

4 ☐ Treatment of B-cell lymphoproliferative disorder

5 ☐ Treatment of viral infection,
specify: _____

6 ☐ Graft failure

7 ☐ Other, specify: _____

If answers 3 – 7 were selected, then answers to following questions should reflect clinical status immediately prior to infusion. This is considered a transplant and a separate report covering this infusion and post-infusion events must be submitted.

TEAM IUBMID **Hematopoietic Reconstitution Posttransplant****403.** Has patient received hematopoietic growth factors or cytokines posttransplant?1 ☐ Yes 0 ☐ NoSpecify agents given as planned therapy to promote engraftment:

<u>Per Protocol:</u>	Yes	No	<u>Date Started</u>			<u>Date Stopped</u>				
			Month	Day	Year	Month	Day	Year		
G-CSF	404. 1 ☐ 0 ☐		405.				406.			
GM-CSF	407. 1 ☐ 0 ☐		408.				409.			
Interleukin-3	410. 1 ☐ 0 ☐		411.				412.			
Interleukin-6	413. 1 ☐ 0 ☐		414.				415.			
PIXY-321	416. 1 ☐ 0 ☐		417.				418.			
Stem Cell Factor (SCF)	419. 1 ☐ 0 ☐		420.				421.			
Blinded growth factor trial, specify agent(s) being studied:	422. 1 ☐ 0 ☐		423.				424.			

Other, specify:

425. 1 ☐ 0 ☐426. 427. **Coding for Indication of Therapy (below)**

1. Intervention for delay/decline in Absolute Neutrophil Count (ANC)
2. Intervention for delay/decline in platelets
3. Intervention for delay/decline in both ANC and platelets
4. Intervention for delay/decline in red blood cell counts
5. Anti-leukemic or tumor agent to prevent relapse
6. Anti-leukemic or tumor agent to treat relapse
7. Other indication

Specify additional agents given:

	Yes	No	<u>Date Started</u>			<u>Date Stopped</u>			<u>Indication</u>	
			Month	Day	Year	Month	Day	Year		
G-CSF	428. 1 ☐ 0 ☐		429.				430.			431. ☐
GM-CSF	432. 1 ☐ 0 ☐		433.				434.			435. ☐
Erythropoietin	436. 1 ☐ 0 ☐		437.				438.			439. ☐
Thrombopoietin	440. 1 ☐ 0 ☐		441.				442.			443. ☐
Interleukin-2	444. 1 ☐ 0 ☐		445.				446.			447. ☐
Interleukin-3	448. 1 ☐ 0 ☐		449.				450.			451. ☐
Interleukin-6	452. 1 ☐ 0 ☐		453.				454.			455. ☐
PIXY-321	456. 1 ☐ 0 ☐		457.				458.			459. ☐
Stem Cell Factor (SCF)	460. 1 ☐ 0 ☐		461.				462.			463. ☐
Interferon-alpha	464. 1 ☐ 0 ☐		465.				466.			467. ☐
Interferon-gamma	468. 1 ☐ 0 ☐		469.				470.			471. ☐
Blinded growth factor trial, specify agent(s) being studied:	472. 1 ☐ 0 ☐		473.				474.			475. ☐

Other, specify:

476. 1 ☐ 0 ☐477. 478. 479. ☐

TEAM IUBMID

480. Did patient receive other courses of growth factors or cytokines posttransplant?

- 1 ☐ Yes — Photocopy Q. 428–479 and answer for each additional course given.
0 ☐ No
8 ☐ Unknown

Granulopoiesis

481. Is (was) there evidence of hematopoietic recovery following the initial bone marrow infusion? (check only one)

1 ☐ Yes, ANC $\geq$ 500/mm³ achieved and sustained for 3 consecutive days	482. Date ANC $\geq$ 500/mm³: (First of 3 consecutive days) Month Day Year 483. Was ANC $\geq$ 1000/mm³ achieved and sustained for 3 consecutive days? 1 ☐ Yes — 0 ☐ No 8 ☐ Unknown 484. Date achieved: ☐ Date unknown Month Day Year (first of 3 consecutive days) Go to Q. 512
2 ☐ Yes, ANC $\geq$ 500/mm³ for 3 consecutive days with subsequent decline in ANC to $<$500/mm³ for greater than 3 days	485. Date ANC $\geq$ 500/mm³: (First of 3 consecutive days) Month Day Year 486. Was ANC $\geq$ 1000/mm³ achieved and sustained for 3 consecutive days? 1 ☐ Yes — 0 ☐ No 8 ☐ Unknown 487. Date achieved: ☐ Date unknown Month Day Year (first of 3 consecutive days) 488. Date of decline in ANC to $<$ 500/mm³ for greater than 3 days: (First of 3 days that ANC declined) Month Day Year 489. Did patient recover and maintain ANC $\geq$ 500/mm³ following the decline? 1 ☐ Yes — 0 ☐ No 490. Date of ANC recovery: Month Day Year Go to Q. 491
3 ☐ No, ANC $\geq$ 500/mm³ was not achieved and there was no evidence of recurrent disease in the bone marrow	Go to Q. 491
4 ☐ No, ANC $\geq$ 500/mm³ was not achieved and there was documented persistent disease in the bone marrow posttransplant	Go to Q. 491

TEAM IUBMID Suspected etiology of failure to achieve ANC $\geq 500/\text{mm}^3$ or of a decline in ANC:

491. Persistent disease or relapse:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

492. Graft versus host disease:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

493. Immune-mediated rejection:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

494. Non-viral infection:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

495. Suspected viral infection:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

Virus suspected:

- | | <u>Yes</u> | <u>No</u> | |
|------|----------------------------|----------------------------|----------------------------------|
| 496. | 1 ☐ | 0 ☐ | Cytomegalovirus (CMV) |
| 497. | 1 ☐ | 0 ☐ | Human Herpes Virus Type 6 (HHV6) |
| 498. | 1 ☐ | 0 ☐ | Herpes Simplex Virus (HSV) |
| 499. | 1 ☐ | 0 ☐ | Varicella |
| 500. | 1 ☐ | 0 ☐ | Other, specify:
_____ |

501. Documented viral infection:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

Virus involved:

- | | <u>Yes</u> | <u>No</u> | |
|------|----------------------------|----------------------------|----------------------------------|
| 502. | 1 ☐ | 0 ☐ | Cytomegalovirus (CMV) |
| 503. | 1 ☐ | 0 ☐ | Human Herpes Virus Type 6 (HHV6) |
| 504. | 1 ☐ | 0 ☐ | Herpes Simplex Virus (HSV) |
| 505. | 1 ☐ | 0 ☐ | Varicella |
| 506. | 1 ☐ | 0 ☐ | Other, specify:
_____ |

507. Drugs:

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown

- | | <u>Yes</u> | <u>No</u> | |
|------|----------------------------|----------------------------|---|
| 508. | 1 ☐ | 0 ☐ | Ganciclovir |
| 509. | 1 ☐ | 0 ☐ | Bactrim, Septra,
Trimethoprim-sulfamethoxazole |
| 510. | 1 ☐ | 0 ☐ | Other, specify:
_____ |

511. Etiology undetermined:

- 1 ☐ Yes
0 ☐ No

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.

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

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

Go to Q. 518

513. Date platelets $\geq 20 \times 10^9/L$:

☐ Date unknown

Month

Day

Year

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

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

Go to Q. 518

515. Date platelets $\geq 50 \times 10^9/L$:

☐ Date unknown

Month

Day

Year

516. Was a platelet count of $\geq 100 \times 10^9/L$ achieved?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

517. Date platelets $\geq 100 \times 10^9/L$:

☐ Date unknown

Month

Day

Year

518. Was patient ever platelet transfusion independent?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

7 ☐ Not applicable
(never
dependent)

519. Date of last (most recent) platelet transfusion*:

☐ Date unknown

Month

Day

Year

**If patient was platelet transfusion independent for ≥ 14 days but subsequently experienced a decline in platelet count and required platelet transfusions, record date of last platelet transfusion before decline in counts. If patient has not required platelet transfusions since initial date of recovery, record date of last platelet transfusion.*

520. Is patient now receiving platelet transfusions?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

Erythropoiesis

521. Has patient received red blood cell (RBC) transfusions within 20 days of the day of last contact?

1 ☐ Yes

0 ☐ No

522. Date of last (most recent) RBC transfusion*:

☐ Date unknown

Month

Day

Year

**If patient was RBC transfusion independent for ≥ 1 month but subsequently experienced a decline in RBC count and required RBC transfusions, record date of last RBC transfusion before decline in counts. If patient has not required RBC transfusions since initial date of recovery, record date of last RBC transfusion.*

523. Is patient now receiving RBC transfusions?

1 ☐ Yes

0 ☐ No

8 ☐ Unknown

TEAM IUBMID

541. Did acute GVHD occur?

- 1 ☐ Yes
 0 ☐ No
 8 ☐ Unknown

Go to Q. 593

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

What was diagnosis based on?

543. Histologic evidence:

- 1 ☐ Yes
 0 ☐ No

Sites:

Yes No

544. 1 ☐ 0 ☐ Skin

545. 1 ☐ 0 ☐ Gut

546. 1 ☐ 0 ☐ Liver

547. 1 ☐ 0 ☐ Other, specify: _____

548. Clinical evidence:

- 1 ☐ Yes
 0 ☐ No

549. Date of onset:
 Month Day Year

550. Was acute GVHD still present at time of this report?

- 1 ☐ Yes
 0 ☐ No
 2 ☐ Progressed to chronic GVHD
 8 ☐ Unknown

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

Stage 0

Stage 1

Stage 2

Stage 3

Stage 4

551. Skin:

- 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

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

- 0 ☐ No diarrhea
 1 ☐ Diarrhea ≤500 ml/day or <280 ml/m²/day
 2 ☐ Diarrhea >500 but ≤1000 ml/day or 280–555 ml/m²/day
 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

553. Liver:

- 1 ☐ Bilirubin <2.0 mg/dL
 2 ☐ Bilirubin 2.0–3.0 mg/dL
 3 ☐ Bilirubin 3.1–6.0 mg/dL
 4 ☐ Bilirubin 6.1–15.0 mg/dL
 5 ☐ Bilirubin >15.0 mg/dL

554. Other organ involvement?

- 1 ☐ Yes
 0 ☐ No

Yes No

555. 1 ☐ 0 ☐ Upper GI tract

556. 1 ☐ 0 ☐ Lung

557. 1 ☐ 0 ☐ Other, specify: _____

TEAM IUBMID 558. Was specific therapy used to treat acute GVHD? 1 ☐ Yes 0 ☐ No — [Go to Q. 593](#)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
559. Methotrexate	0 ☐	1 ☐	2 ☐	3 ☐	560. 1 ☐ 0 ☐
561. Cyclosporine	0 ☐	1 ☐	2 ☐	3 ☐	562. 1 ☐ 0 ☐
563. FK 506 (Tacrolimus)	0 ☐	1 ☐	2 ☐	3 ☐	564. 1 ☐ 0 ☐
565. Systemic Corticosteroids	0 ☐	1 ☐	2 ☐	3 ☐	566. 1 ☐ 0 ☐
567. Topical Corticosteroids	0 ☐	1 ☐	2 ☐	3 ☐	568. 1 ☐ 0 ☐
569. ALS, ALG, ATS, ATG	0 ☐	1 ☐	2 ☐	3 ☐	570. 1 ☐ 0 ☐
571. Azathioprine	0 ☐	1 ☐	2 ☐	3 ☐	572. 1 ☐ 0 ☐
573. Cyclo- phosphamide	0 ☐	1 ☐	2 ☐	3 ☐	574. 1 ☐ 0 ☐
575. Thalidomide	0 ☐	1 ☐	2 ☐	3 ☐	576. 1 ☐ 0 ☐

In vivo anti-T-lymphocyte monoclonal antibody:

577. Anti IL-2	0 ☐	1 ☐	2 ☐	3 ☐	578. 1 ☐ 0 ☐
579. Anti CD 25	0 ☐	1 ☐	2 ☐	3 ☐	580. 1 ☐ 0 ☐
581. Campath	0 ☐	1 ☐	2 ☐	3 ☐	582. 1 ☐ 0 ☐
583. OKT3	0 ☐	1 ☐	2 ☐	3 ☐	584. 1 ☐ 0 ☐
585. Other, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	586. 1 ☐ 0 ☐
587. In vivo immunotoxin, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	588. 1 ☐ 0 ☐
589. Blinded randomized trial; specify agent being studied: _____	0 ☐	1 ☐	2 ☐	3 ☐	590. 1 ☐ 0 ☐
591. Other, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	592. 1 ☐ 0 ☐

TEAM

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Indicate organ involvement with chronic GVHD from list below:

	<u>Yes</u>	<u>No</u>	
Skin/Hair:	612. 1 ☐	0 ☐	Subclinical (biopsy findings only)
	613. 1 ☐	0 ☐	Rash
	614. 1 ☐	0 ☐	Scleroderma
	615. 1 ☐	0 ☐	Dyspigmentation
	616. 1 ☐	0 ☐	Contractures
	617. 1 ☐	0 ☐	Alopecia
	618. 1 ☐	0 ☐	Other skin/hair involvement, specify: _____
Eyes:	619. 1 ☐	0 ☐	Dry eyes
	620. 1 ☐	0 ☐	Corneal erosion/conjunctivitis
	621. 1 ☐	0 ☐	Other eye involvement, specify: _____
Mouth:	622. 1 ☐	0 ☐	Lichenoid changes
	623. 1 ☐	0 ☐	Mucositis/ulcers
	624. 1 ☐	0 ☐	Other mouth involvement, specify: _____
Lung:	625. 1 ☐	0 ☐	Bronchiolitis obliterans
	626. 1 ☐	0 ☐	Other lung involvement, specify: _____
GI Tract:	627. 1 ☐	0 ☐	Esophageal involvement
	628. 1 ☐	0 ☐	Chronic nausea/vomiting
	629. 1 ☐	0 ☐	Chronic diarrhea
	630. 1 ☐	0 ☐	Malabsorption
	631. 1 ☐	0 ☐	Other GI tract involvement, specify: _____
Liver:	632. 1 ☐	0 ☐	Liver involvement, specify: _____
GU Tract:	633. 1 ☐	0 ☐	Vaginitis/stricture
	634. 1 ☐	0 ☐	Other GU involvement, specify: _____
Musculoskeletal:	635. 1 ☐	0 ☐	Arthritis
	636. 1 ☐	0 ☐	Myositis
	637. 1 ☐	0 ☐	Myasthenia
	638. 1 ☐	0 ☐	Other musculoskeletal involvement, specify: _____
Hematologic:	639. 1 ☐	0 ☐	Thrombocytopenia
	640. 1 ☐	0 ☐	Eosinophilia
	641. 1 ☐	0 ☐	Autoantibodies
	642. 1 ☐	0 ☐	Other hematologic involvement, specify: _____
Other:	643. 1 ☐	0 ☐	Specify: _____

TEAM IUBMID 644. Was specific therapy used to treat chronic GVHD? 1 ☐ Yes 0 ☐ No — For each agent listed below indicate whether or not it was used to treat chronic GVHD

	No, drug not given	Drug continued at prophylactic dose	Yes, drug started	Yes, dose increased		Still taking?	
						Yes	No
645. ALS, ALG, ATS, ATG	0 ☐	1 ☐	2 ☐	3 ☐	646.	1 ☐	0 ☐
647. Azathioprine	0 ☐	1 ☐	2 ☐	3 ☐	648.	1 ☐	0 ☐
649. Cyclosporine	0 ☐	1 ☐	2 ☐	3 ☐	650.	1 ☐	0 ☐
651. FK 506 (Tacrolimus)	0 ☐	1 ☐	2 ☐	3 ☐	652.	1 ☐	0 ☐
653. Systemic Corticosteroids	0 ☐	1 ☐	2 ☐	3 ☐	654.	1 ☐	0 ☐
655. Topical Corticosteroids	0 ☐	1 ☐	2 ☐	3 ☐	656.	1 ☐	0 ☐
657. Cyclo- phosphamide	0 ☐	1 ☐	2 ☐	3 ☐	658.	1 ☐	0 ☐
659. Thalidomide	0 ☐	1 ☐	2 ☐	3 ☐	660.	1 ☐	0 ☐

In vivo anti-T-lymphocyte monoclonal antibody

661. Anti IL-2	0 ☐	1 ☐	2 ☐	3 ☐	662.	1 ☐	0 ☐
663. Anti CD 25	0 ☐	1 ☐	2 ☐	3 ☐	664.	1 ☐	0 ☐
665. Campath	0 ☐	1 ☐	2 ☐	3 ☐	666.	1 ☐	0 ☐
667. OKT3	0 ☐	1 ☐	2 ☐	3 ☐	668.	1 ☐	0 ☐
669. Other, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	670.	1 ☐	0 ☐
671. In vivo immunotoxin, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	672.	1 ☐	0 ☐
673. Blinded randomized trial; specify agent being studied: _____	0 ☐	1 ☐	2 ☐	3 ☐	674.	1 ☐	0 ☐
675. Other, specify: _____	0 ☐	1 ☐	2 ☐	3 ☐	676.	1 ☐	0 ☐

TEAM IUBMID

677. Is patient still receiving treatment for chronic GVHD?

1 ☐ Yes0 ☐ No

678. Date last treatment was administered:

Month

Day

Year

679. Is chronic GVHD still present?

1 ☐ Yes0 ☐ No2 ☐ No symptoms, but patient still receiving treatment

Other Treatment and Clinical Status After Start of Conditioning

680. Were transfusions given at any time after the start of conditioning to present?

1 ☐ Yes0 ☐ No

	Yes	No
--	-----	----

681. 1 ☐ 0 ☐ Did patient receive only CMV-negative blood products?682. 1 ☐ 0 ☐ Were blood products filtered to remove leukocytes?683. 1 ☐ 0 ☐ Were all transfusions irradiated?684. Number of RBC transfusions in first 60 days: units685. Number of platelet transfusions in first 60 days: units686. Did patient receive any of the following agents for infection prophylaxis after start of conditioning?1 ☐ Yes0 ☐ No

	Yes	No
--	-----	----

1 ☐ 0 ☐ Systemic antibacterial antibiotics1 ☐ 0 ☐ Nonabsorbable antibiotics687. 1 ☐ 0 ☐ Polyclonal IV gamma globulin (not ATG)688. 1 ☐ 0 ☐ CMV/hyperimmune gamma globulin689. 1 ☐ 0 ☐ IV amphotericin690. 1 ☐ 0 ☐ Fluconazole691. 1 ☐ 0 ☐ Itraconazole692. 1 ☐ 0 ☐ Other systemic antifungal agent, specify: _____693. 1 ☐ 0 ☐ Acyclovir694. 1 ☐ 0 ☐ Ganciclovir (DHPG)695. 1 ☐ 0 ☐ Foscarnet696. 1 ☐ 0 ☐ Other antiviral agent, specify: _____697. 1 ☐ 0 ☐ Trimethoprim-sulfamethoxazole (Bactrim/Septa)698. 1 ☐ 0 ☐ Pentamidine inhaled699. 1 ☐ 0 ☐ Pentamidine IV700. 1 ☐ 0 ☐ Dapsone701. 1 ☐ 0 ☐ Other pneumocystis prophylaxis, specify: _____702. 1 ☐ 0 ☐ Other, specify: _____

TEAM IUBMID 703. Did patient develop clinically significant infection after start of conditioning? 1 ☐ Yes 0 ☐ No

Select site and organism from lists shown on the next page and place number in the appropriate spaces. If more than one site or organism was involved, list one site of infection and organism on the first line; second site and/or organism on second line.

		Date of Onset			Did infection resolve?	
		Month	Day	Year	Yes	No
704. ☐ Bacterial	Site	Organism				
Typical	First	705.	706.	707.		
	Second	709.	710.	711.		
Atypical	First	716.	717.	718.		
	Second	720.	721.	722.		
724. Other atypical bacterium, specify:						
727. ☐ Fungal	First	728.	729.	730.		
	Second	732.	733.	734.		
736. Other fungus, specify:						
739. ☐ Viral	First	740.	741.	742.		
	Second	744.	745.	746.		
748. Other virus, specify:						
751. ☐ Parasitic	First	752.	753.	754.		
	Second	756.	757.	758.		
760. Other parasite, specify:						
763. ☐ No organism identified	First	764.	765.	766.		
	Second	768.	769.	770.		

Codes for Common Sites of Infection

- | | | | |
|----|---|----|--|
| 01 | Blood/buffy coat | 40 | <u>Genito-Urinary Tract unspecified</u> |
| 02 | Disseminated – generalized,
isolated at 3 or more distinct sites | 41 | Kidneys, renal pelvis, ureters and bladder |
| 03 | <u>Central Nervous System unspecified</u> | 42 | Prostate |
| 04 | Brain | 43 | Testes |
| 05 | Spinal cord | 44 | Fallopian tubes, uterus, cervix |
| 06 | Meninges and CSF | 45 | Vagina |
| 10 | <u>Gastrointestinal Tract unspecified</u> | 50 | <u>Skin unspecified</u> |
| 11 | Lips | 51 | Genital area |
| 12 | Tongue, oral cavity and oro-pharynx | 52 | Cellulitis |
| 13 | Esophagus | 53 | Herpes Zoster |
| 14 | Stomach | 54 | Rash, pustules or abscesses not typical
of any of the above |
| 15 | Gallbladder and biliary tree (not hepatitis), pancreas | 60 | Central venous catheter, not otherwise specified |
| 16 | Small intestine | 61 | Catheter insertion site |
| 17 | Large intestine | 62 | Catheter tip |
| 18 | Feces/stool | 70 | Eyes |
| 19 | Peritoneum | 75 | Ear |
| 20 | Liver | 80 | <u>Other unspecified</u> |
| 30 | <u>Respiratory unspecified</u> | 81 | Joints |
| 31 | Upper airway and nasopharynx | 82 | Bone marrow |
| 32 | Laryngitis/larynx | 83 | Bone cortex (osteomyelitis) |
| 33 | Lower respiratory tract (lung) | 84 | Muscle (excluding cardiac) |
| 34 | Pleural cavity, pleural fluid | 85 | Cardiac (endocardium, myocardium, pericardium) |
| 35 | Sinuses | 86 | Lymph nodes |
| | | 87 | Spleen |

Codes for Commonly Reported Organisms

1. Bacteria

(Indicate code for atypical bacteria;
list bacterium for non-atypical bacteria.)

- 100 Atypical bacteria, not otherwise specified
- 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

2. Fungal Infections

- 200 Candida, not otherwise specified
- 201 Candida albicans
- 202 Candida krusei
- 203 Candida parapsilosis
- 204 Candida tropicalis
- 205 Torulopsis glabrata (a subspecies of candida)
- 209 Candida, other
- 210 Aspergillus, not otherwise specified
- 211 Aspergillus flavus
- 212 Aspergillus fumigatus
- 213 Aspergillus niger
- 219 Aspergillus, other
- 220 Cryptococcus species
- 230 Fusarium species
- 240 Mucormycosis (zygomycetes, rhizopus)
- 250 Yeast, not otherwise specified
- 259 Other fungus, specify

3. 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

4. Parasite Infections

- 401 Pneumocystis (PCP)
- 402 Toxoplasma
- 403 Giardia
- 404 Cryptosporidium
- 409 Other parasite (amebiasis, echinococcal cyst,
trichomonas – either vaginal or gingivitis),
specify

5. Other Infections

- 509 No organism identified

TEAM IUBMID **Pulmonary function**

775. Has patient developed interstitial pneumonitis (IPn)?

*Interstitial pneumonitis is characterized by hypoxia and diffuse interstitial infiltrates on chest x-ray not caused by fluid overload.*1 ☐ Yes0 ☐ No776. How many episodes of IPn occurred? *Note: If more than one episode of IPn, photocopy this page and complete Q. 775 – 795 for subsequent episode(s).*777. Date of onset of IPn:

Month Day Year

778. Were diagnostic tests other than radiographic studies done?

1 ☐ Yes0 ☐ No

Diagnosis was evaluated by:

Yes No779. 1 ☐ 0 ☐ Bronchoalveolar lavage780. 1 ☐ 0 ☐ Transbronchial biopsy781. 1 ☐ 0 ☐ Open lung biopsy782. 1 ☐ 0 ☐ Autopsy783. 1 ☐ 0 ☐ Other, specify: _____

784. Was an organism isolated?

1 ☐ Yes0 ☐ No (idiopathic,
or no organism
isolated)

Etiology:

Yes No785. 1 ☐ 0 ☐ Pneumocystis carinii786. 1 ☐ 0 ☐ Aspergillus787. 1 ☐ 0 ☐ Candida toxoplasma788. 1 ☐ 0 ☐ Respiratory syncytial virus789. 1 ☐ 0 ☐ Cytomegalovirus790. 1 ☐ 0 ☐ Herpes simplex791. 1 ☐ 0 ☐ Adenovirus792. 1 ☐ 0 ☐ Human herpes virus 6793. 1 ☐ 0 ☐ Other virus, specify: _____794. 1 ☐ 0 ☐ Other, specify: _____

795. Has interstitial pneumonitis resolved?

1 ☐ Yes0 ☐ No8 ☐ Unknown

TEAM IUBMID 796. Did patient develop pulmonary abnormalities other than interstitial pneumonitis after start of conditioning?1 ☐ Yes0 ☐ No

797. Did patient develop Acute Respiratory Distress Syndrome (ARDS)?

1 ☐ Yes0 ☐ No

798. Date of onset of ARDS:

Month Day Year

799. Were diagnostic tests done?

1 ☐ Yes0 ☐ No

Diagnosis was evaluated by:

Yes No800. 1 ☐ 0 ☐ Bronchoalveolar lavage801. 1 ☐ 0 ☐ Transbronchial biopsy802. 1 ☐ 0 ☐ Open lung biopsy803. 1 ☐ 0 ☐ Autopsy804. 1 ☐ 0 ☐ Other, specify: _____

805. Did patient develop bronchiolitis obliterans?

1 ☐ Yes0 ☐ No

806. Date of onset:

Month Day Year

807. Were diagnostic tests done?

1 ☐ Yes0 ☐ No

Diagnosis was evaluated by:

Yes No808. 1 ☐ 0 ☐ Bronchoalveolar lavage809. 1 ☐ 0 ☐ Transbronchial biopsy810. 1 ☐ 0 ☐ Open lung biopsy811. 1 ☐ 0 ☐ Autopsy812. 1 ☐ 0 ☐ Other, specify: _____

813. Did patient develop pulmonary hemorrhage?

1 ☐ Yes0 ☐ No

814. Date of onset:

Month Day Year

815. Were diagnostic tests done?

1 ☐ Yes0 ☐ No

Diagnosis was evaluated by:

Yes No816. 1 ☐ 0 ☐ Bronchoalveolar lavage817. 1 ☐ 0 ☐ Transbronchial biopsy818. 1 ☐ 0 ☐ Open lung biopsy819. 1 ☐ 0 ☐ Autopsy820. 1 ☐ 0 ☐ Other, specify: _____

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

1 ☐ Yes0 ☐ No

822. Specify: _____

TEAM IUBMID **Liver function**823. Patient's maximum total bilirubin
in the first 100 days posttransplant: .

824. Unit of measurement for bilirubin:

• 1 ☐ mg/dL 2 ☐ μ mol/L825. Date of maximum total bilirubin
in the first 100 days posttransplant:
Month Day Year826. Patient's bilirubin on day of last contact:
(Refer to Q. 386, page 17 for date) .

827. Unit of measurement for bilirubin:

1 ☐ mg/dL 2 ☐ μ mol/L

828. Did patient develop any of the following clinical signs/symptoms of abnormal liver function?

1 ☐ Yes0 ☐ No

	Yes	No	
829.	1 ☐	0 ☐	Jaundice
830.	1 ☐	0 ☐	Hepatomegaly
831.	1 ☐	0 ☐	Right upper quadrant pain
832.	1 ☐	0 ☐	Ascites
833.	1 ☐	0 ☐	Weight gain (>5%)
834.	1 ☐	0 ☐	Other, specify: _____

835. Did patient develop non-infectious liver toxicity after conditioning?

1 ☐ Yes0 ☐ No836. What was the date of onset?
Month Day Year

Etiology:

	Yes	No	
837.	1 ☐	0 ☐	Veno-occlusive disease
838.	1 ☐	0 ☐	Other, specify: _____
839.	1 ☐	0 ☐	Unknown

Diagnosis was based on:

	Yes	No	
840.	1 ☐	0 ☐	Clinical signs and symptoms (see Q. 828)
841.	1 ☐	0 ☐	Elevated liver enzymes
842.	1 ☐	0 ☐	Biopsy
843.	1 ☐	0 ☐	Autopsy
844.	1 ☐	0 ☐	Ultrasonography
845.	1 ☐	0 ☐	Doppler
846.	1 ☐	0 ☐	Other, specify: _____

847. Has liver toxicity resolved?

1 ☐ Yes0 ☐ No

TEAM IUBMID

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

1 ☐ Yes0 ☐ NoYes No849. 1 ☐ 0 ☐ Renal failure requiring dialysis850. 1 ☐ 0 ☐ TTP/HUS or similar syndrome851. 1 ☐ 0 ☐ Hemorrhage, specify site: _____856. 1 ☐ 0 ☐ Hemorrhagic cystitis857. 1 ☐ 0 ☐ Seizures858. 1 ☐ 0 ☐ Cataracts859. 1 ☐ 0 ☐ Avascular necrosis860. 1 ☐ 0 ☐ Hypothyroidism861. 1 ☐ 0 ☐ Gonadal dysfunction862. 1 ☐ 0 ☐ Growth hormone deficiency/growth disturbance863. 1 ☐ 0 ☐ Other, specify: _____Yes No852. 1 ☐ 0 ☐ CNS853. 1 ☐ 0 ☐ Upper GI tract854. 1 ☐ 0 ☐ Lower GI tract855. 1 ☐ 0 ☐ Other, specify: _____

864. Did a new malignancy, lymphoproliferative or myeloproliferative disorder appear? (If more than one new malignancy developed, copy this page and complete for each new cancer)

1 ☐ Yes0 ☐ No

865. Date of diagnosis:

Month

Day

Year

866. Origin of cells:

1 ☐ Host8 ☐ Unknown2 ☐ Donor7 ☐ Not tested

Diagnosis (*send copy of pathology report/other documentation*):

Yes No867. 1 ☐ 0 ☐ Clonal cytogenetic abnormality without leukemia or MDS868. 1 ☐ 0 ☐ Acute myeloid leukemia869. 1 ☐ 0 ☐ Other leukemia, specify: _____870. 1 ☐ 0 ☐ Myelodysplasia871. 1 ☐ 0 ☐ Lymphoma or lymphoproliferative disease872. EBV positive? 1 ☐ Yes 0 ☐ No 8 ☐ Unknown873. 1 ☐ 0 ☐ Hodgkin disease875. 1 ☐ 0 ☐ Other cancer

876. Primary site: _____

877. Histologic type: _____

878. Behavior:

1 ☐ Benign2 ☐ In situ3 ☐ Malignant/invasive8 ☐ Unknown

TEAM IUBMID

Survival and Functional Status

879. Was patient discharged from hospital after transplant?

1 ☐ Yes

0 ☐ No

7 ☐ Not applicable,
high-dose therapy given as outpatient

880. Date of first discharge from
hospital after transplant:

Month
Day
Year

881. **Autografts only:** Total number inpatient days in first 60 days after start of high-dose therapy:

882. **Allografts only:** Total number inpatient days in first 100 days after start of high-dose therapy:

883. Was patient alive on the day of last contact? (Refer to Q. 386, page 17 for date):

1 ☐ Yes

0 ☐ No

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

Go to Q. 895

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 restriction 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

(If patient is alive, answer Q.885–894; if dead, skip to Q. 895)

885. Patient (age ≥ 6 years) currently attends school:

1 ☐ Yes

0 ☐ No

886. 1 ☐ Part-time 2 ☐ Full-time 8 ☐ Unknown, whether part-time or full-time

887. Date returned to school:

Month Year

888. Patient was employed outside the home prior to current illness:

1 ☐ Yes

0 ☐ No

889. Patient has returned to work:

1 ☐ Yes

0 ☐ No

890. Date returned to work:

Month Year

891. Patient able to work but is not employed:

1 ☐ Yes

0 ☐ No

892. Patient has resumed all household activities:

1 ☐ Yes

0 ☐ No

893. Date resumed
all activities:

Month Year

894. Patient is a student:

1 ☐ Yes

0 ☐ No

TEAM IUBMID **Death Information**895. Date of death:
Month Day Year

Cause(s) of death:

Enter appropriate cause of death below. If a code number for "Other, specify" is entered, write the cause in the space provided.

896. Primary: Specify: _____

Contributing or secondary causes:

897. Specify: _____898. Specify: _____899. Specify: _____900. Specify: _____901. Specify: _____**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 Cytomegalovirus (CMV)

32 Viral, other

33 Pneumocystis (PCP)

34 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*NOTE: Code "70" may only be used as a
primary cause of death, not a contributing
or secondary cause.*

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

89 Other organ failure, specify

90 Secondary malignancy

100 Hemorrhage

110 Accidental death

900 Other, specify

902. Was cause of death confirmed by autopsy?

1 ☐ Yes0 ☐ No8 ☐ Unknown6 ☐ Pending**Send copy of autopsy report when available**

TEAM IUBMID **FOR REGISTRY USE ONLY:**I.D. -

Date received:

Registry: IBMTR ABMTR (circle one)

Confidential/Socioeconomic Information903. Patient's First Name: 904. Patient's Last Name: 905. Patient's state of residence (US only): 906. Zip code for place of patient's residence (US only): -907. Country of residence (if non-US):

908. Does patient have a US Social Security Number or Canadian Social Insurance Number?

- 1 ☐ Yes
0 ☐ No
8 ☐ Unknown
7 ☐ Not applicable

909. Social Security or
Social Insurance Number: 910. (For patients ≥ 18 years of age) What is patient's marital status? (check one)

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

911. (For patients ≥ 18 years of age) What is the highest grade patient finished in school?

- 1 ☐ 1 - 8 grades
2 ☐ 9 - 11 grades
3 ☐ 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

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912. What type of health insurance does patient have? (*check all that apply*)

- 0 ☐ No Insurance
- 1 ☐ Medicaid
- 2 ☐ Medicare (US)
- 3 ☐ Disability Insurance
- 4 ☐ HMO
- 5 ☐ Individual Health Insurance
- 6 ☐ Group Health Insurance
- 7 ☐ National Health Insurance (non-US)
- 8 ☐ V.A./Military
- 9 ☐ Other, specify: _____

913. (*U.S. patients only*) Type of fee reimbursement:

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

914. Which category best describes patient's occupation?

If not currently employed, which best describes patient's LAST job? (check only one)

- 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 hairdresser)
- 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, please describe: _____
- 88 ☐ Unknown

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

INSTITUTIONAL INFORMATION

TEAM				
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IUBMID					
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(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:

Registry: IBMTR ABMTR (circle one)

Date of report:

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--	--

Month Day Year

1. Signed: _____

Person completing this form / Please print name

2. Date form completed:

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--	--

Month Day Year

3. Name of doctor for correspondence: _____

Institution: _____

Address: _____

[illegible]

Extension:

--	--	--	--	--

Fax: _____

4. Make reimbursement check payable to: _____

5. 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).

6. A complete report of transplant consists of the following three forms.

Check when complete:

- ☐ A (white) CORE FORM
- ☐ An appropriate (blue or pink) graft-specific insert (Insert ALLOBM, AUTOPB, or AUTOBM)
- ☐ An appropriate (ivory) disease-specific insert (Inserts I through XVI)