

OMB No: 0915-
Expiration Date:

Public Burden Statement

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is _____. Public reporting burden for this collection of information is estimated to average 0.85 hours per response when collected at 100 days post transplant, 1.0 hours per response when collected at 6 and 12 months post transplant, and 1.5 hours per response annually thereafter, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.



Post-Transplant Essential Data
 Note: ">100 Days Report" answer *since last report*
 ○ = symbol for answer that is only valid on >d100 evaluation.



CIBMTR Center #: CIBMTR Recipient ID#: Report represents: Day 100 6 months Annual

MALIGNANT DISEASE EVALUATION FOR THIS HSCT
(non-malignant disease skip disease evaluation)

WAS A CR EVER ACHIEVED IN REPOSE TO HSCT
(including any therapy planned as of Day 0, excluding any change in therapy in response to disease assessment)?

- Recipient already in CR at start of preparative regimen (N/Apl)
 Yes, post-HSCT CR achieved, date: _____
 ○ First CR date reported previously
 No, never in CR from HSCT, date assessed: _____
 Not evaluated _____

FIRST RELAPSE OR PROGRESSION AFTER HSCT
(in this period, any type, not persistent disease)

- Yes, answer all 3 methods. If used, give the date used and the results.
 No—(skip to 'Additional Treatment' below)

- Relapse/progression detected by **molecular method**:
 Yes, Date first seen: _____
 No, Date of Assessment: _____
 ○ Previously reported Not evaluated

- Relapse/progression detected by **cytogenetic/FISH method**:
 Yes, Date first seen: _____
 No, Date of Assessment: _____
 ○ Previously reported Not evaluated

- Relapse/progression detected by **clinical/hematological method**:
 Yes, Date first seen: _____
 No, Date of Assessment: _____
 ○ Previously reported Not evaluated

ADDITIONAL TREATMENT?

- Yes No—(skip to 'Method' below)
Yes No
 DCI (allo only)
 (also complete 'DCI' section)
 Planned (given regardless of disease status/assessment post-HSCT)
 Not planned (given for relapse, progression, or persistent disease)

METHOD OF LATEST DISEASE ASSESSMENT
(record most recent of each)

* In some circumstances, disease may be detected by molecular or cytogenetic testing, but may not be considered a relapse or progression. It should still be reported.

Method	Disease detected?		
	No	Yes	Not evaluated
Molecular*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was the status considered a disease relapse or progression? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date latest assessed: _____		
Cytogenetic/FISH*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was the status considered a disease relapse or progression? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date latest assessed: _____		
Clinical/Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Date latest assessed: _____		

If a previous HSCT was performed for a different disease than this HSCT, give status of original disease and date determined:

- CR Not in CR Date: _____

DONOR CELLULAR INFUSION (DCI)

Date of **first** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
 Lymphocytes Fibroblasts Dendritic cells
 Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
 Treat disease Mixed Chimerism
 Treat PTLD, EBV-Lym Loss/Decreased Chimerism
 Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Date of **second** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
 Lymphocytes Fibroblasts Dendritic cells
 Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
 Treat disease Mixed Chimerism
 Treat PTLD, EBV-Lym Loss/Decreased Chimerism
 Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Date of **third** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
 Lymphocytes Fibroblasts Dendritic cells
 Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
 Treat disease Mixed Chimerism
 Treat PTLD, EBV-Lym Loss/Decreased Chimerism
 Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Were there more than 3 instances of DCI infusions in this reporting period? Yes No

If yes, copy this page and continue numbering fourth, fifth, etc.