

OMB No: 0915-
Expiration Date:

Public Burden Statement

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Hematopoietic Stem Cell Transplant (HSCT) Infusion

Registry Use Only

Sequence Number:

Date Received:

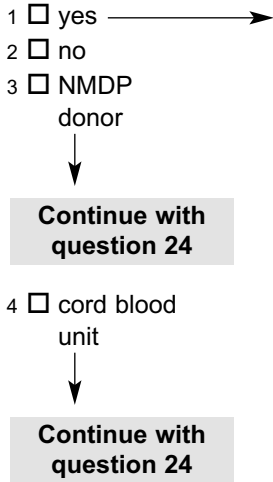
CIBMTR Center Number:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
CIBMTR Recipient ID:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
NMDP Donor ID:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	
NMDP Cord Blood Unit ID:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/> Non-NMDP cord blood unit *
* For non-NMDP cords, see page 11 to report CBU ID and donor demographics.		
Today's Date:	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> Month </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> Day </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Year </div> </div>	
Date of HSCT for which this form is being completed:	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> Month </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> Day </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Year </div> </div>	
HSCT type:	<input type="checkbox"/> autologous <input type="checkbox"/> allogeneic, unrelated <input type="checkbox"/> allogeneic, related <input type="checkbox"/> syngeneic (identical twin)	
Product type:	<input type="checkbox"/> marrow <input type="checkbox"/> PBSC <input type="checkbox"/> cord blood <input type="checkbox"/> other product, specify: _____ <small>(check only one)</small>	
	<input type="checkbox"/> multiple cord blood units infused	

This form must be completed for all recipients who receive a HSCT product. If more than one type of HSCT product is infused, each product type must be analyzed and reported separately. Questions followed by the symbol indicate additional information necessary to complete the question is referenced in the forms instruction manual; indicates an appendix.

A series of collections should be considered a single product when they are all from the same donor and use the same collection method and technique (and mobilization, if applicable), even if the collections are performed on different days.

Pre-Collection Therapy

1. Did the donor receive treatment, prior to any stem cell harvest, to enhance the product collection for this HSCT?
 (If the HSCT product was from an NMDP donor, or the product is a cord blood unit, then continue with question 20.)



Specify treatment(s): <i>(select all that apply)</i> 2. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no <i>(autologous only)</i> Chemotherapy →	Report details on disease-specific insert
3. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no <i>(autologous only)</i> Anti-CD20 (rituximab, Rituxan) →	Report details on disease-specific insert
4. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Growth factor(s) →	If yes, specify growth factor(s): 5. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no G-CSF 6. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no GM-CSF 7. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other →
8. Specify: <input style="width: 100%;" type="text"/>	
9. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other treatment →	10. Specify treatment: _____


Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

CIBMTR Center Number:

CIBMTR Recipient ID:

Product Collection

11. Date of product collection: / /
Month Day Year

12. Was more than one collection required for this HSCT? 

- 1 yes
2 no

13. Specify the number of subsequent days of collection in this episode:

Complete a separate product form for each subsequent collection that was not part of this mobilization.

14. Were anticoagulants added to the product during collection?

- 1 yes
2 no

Specify anticoagulant(s):

15. Acid citrate dextrose (ACD)

- 1 yes
2 no

16. Citrate phosphate dextrose (CPD)

- 1 yes
2 no

17. Heparin

- 1 yes
2 no

18. Other anticoagulant

- 1 yes
2 no

19. Specify other anticoagulant:

Product Transport and Receipt

20. Was this product collected off-site and shipped to your facility?

- 1 yes
2 no

21. Date of receipt of product at your facility: / /
Month Day Year

22. Time of receipt of product (24-hour clock): : 1 standard time
Hour Minute 2 daylight savings time

23. Specify the shipping environment of the product(s):

- 1 frozen gel pack
2 frozen cord blood unit(s)
3 room temperature per transplant center request
4 other temperature

24. Specify shipping environment:

25. (Cord blood product only) Were the secondary containers (e.g., insulated shipping containers and unit cassette) intact when they arrived at your center?

- 1 yes
2 no

CIBMTR Center Number:

CIBMTR Recipient ID:

26. (Cord blood product only) Was the cord blood unit completely frozen when it arrived at your center?

- 1 yes
- 2 no

27. (Cord blood product only) Was the cord blood unit stored at your center prior to thawing?

- 1 yes
- 2 no

28. Specify the storage method used for the cord blood unit:

- 1 liquid nitrogen
- 2 vapor phase
- 3 electric freezer

29. Temperature during storage: — ° C

30. Date storage started:

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month	Day	Year

Product Processing / Manipulation

31. Was a fresh product received, then cryopreserved at your facility prior to infusion?

- 1 yes
- 2 no
- 3 not applicable, cord blood unit

32. Was the product thawed from a cryopreserved state prior to infusion?

- 1 yes
- 2 no

33. Was the entire product thawed?

- 1 yes
- 2 no

34. Was a compartment of the bag thawed?

- 1 yes
- 2 no

35. Were there multiple product bags?

- 1 yes
- 2 no

36. Specify number of bags thawed:

37. Date thawing process initiated:

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month	Day	Year

38. Time at initiation of thaw (24-hour clock):

<input type="text"/> <input type="text"/>	:	<input type="text"/> <input type="text"/>	1 <input type="checkbox"/> standard time
Hour		Minute	2 <input type="checkbox"/> daylight savings time

39. Time at completion of thaw (24-hour clock):

<input type="text"/> <input type="text"/>	:	<input type="text"/> <input type="text"/>	1 <input type="checkbox"/> standard time
Hour		Minute	2 <input type="checkbox"/> daylight savings time

40. Was the primary container (e.g., cord blood unit bag) intact upon thawing?

- 1 yes
- 2 no

CIBMTR Center Number:

□ □ □ □ □ □ □ □

CIBMTR Recipient ID:

□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

41. What method was used to thaw the product?

- 1 no wash — thawed at bedside, then infused
- 2 DMSO dilution — thawed in lab (added dextran and albumin), then infused
- 3 washed — thawed in lab (added dextran and albumin), spun and reconstituted in dextran albumin, then infused
- 4 other method →

42. Specify other thaw method: _____

43. Did any adverse events or incidents occur while thawing the product?

- 1 yes
- 2 no

44. Was the product manipulated prior to infusion?

- 1 yes →
- 2 no

If autologous product, continue with question 92; if allogeneic product, continue with question 141.

45. Specify portion manipulated:

- 1 entire product
- 2 portion of product

Specify all methods used to manipulate the product:

46. ABO incompatibility (RBC depletion)

- 1 yes →
- 2 no

Specify method:

- 47. 1 yes 2 no Buffy coat preparation
- 48. 1 yes 2 no Cell separator (i.e., COBE Spectra)
- 49. 1 yes 2 no Density gradient separation (i.e., Ficoll)
- 50. 1 yes 2 no Plasma removal
- 51. 1 yes 2 no Sedimentation (i.e., hetastarch)
- 52. 1 yes 2 no Other →

53. Specify: _____

54. Ex-vivo expansion


- 1 yes
- 2 no

55. Genetic manipulation (gene transfer / transduction)

- 1 yes
- 2 no

56. Volume reduction

- 1 yes
- 2 no

57. CD34+ selection 

- 1 yes →
- 2 no

58. Specify cell selection system used:

- 1 CliniMACS / CliniMax
- 2 Isolex
- 3 other →

59. Specify system: _____


CIBMTR Center Number:

CIBMTR Recipient ID:

60. T-cell depletion

- 1 yes →
- 2 no

Specify method:

- 61. 1 yes 2 no antibody affinity column →
- 62. 1 yes 2 no antibody coated plates →
- 63. 1 yes 2 no antibody coated plates and soybean lectin →
- 64. 1 yes 2 no antibody + complement →
- 65. 1 yes 2 no antibody + toxin →
- 66. 1 yes 2 no immunomagnetic beads →
- 67. 1 yes 2 no elutriation
- 68. 1 yes 2 no CD34 affinity column plus sheep red blood cell rosetting 
- 69. 1 yes 2 no other →

Report the antibodies used for T-cell depletion at question 73.

70. Specify:

71. Other manipulation

- 1 yes →
- 2 no

72. Specify:

73. Were antibodies used during product manipulation?

- 1 yes →
- 2 no

Specify antibodies:

- 74. 1 yes 2 no anti CD2
- 75. 1 yes 2 no anti CD3
- 76. 1 yes 2 no anti CD4
- 77. 1 yes 2 no anti CD5
- 78. 1 yes 2 no anti CD6
- 79. 1 yes 2 no anti CD7
- 80. 1 yes 2 no anti CD8
- 81. 1 yes 2 no anti CD34
- 82. 1 yes 2 no anti TCR alpha / beta (T10-B9)
- 83. 1 yes 2 no OKT-3
- 84. 1 yes 2 no other CD3 →

85. Specify:

- 86. 1 yes 2 no anti CD52 →

Specify antibodies:
yes no
87. 1 2 campath-NOS
88. 1 2 campath-1G
89. 1 2 campath-1H

- 90. 1 yes 2 no other antibody →

91. Specify:

Autologous Products Only

The following section refers to autologous products only, including autologous cord blood; if this is not an autologous HSCT, continue with the Product Analysis section at question 141.

92. Were tumor cells detected in the recipient or autologous product prior to HSCT?

- 1 yes
- 2 no

Specify tumor cell detection method used, and site(s) of tumor cells:

93. Routine histopathology

- 1 yes
- 2 no

Specify site(s):

- 94. 1 yes 2 no 3 not tested Circulating blood cells
- 95. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 96. 1 yes 2 no 3 not tested Collected cells, before purging

97. Polymerase chain reaction (PCR)

- 1 yes
- 2 no

Specify site(s):

- 98. 1 yes 2 no 3 not tested Circulating blood cells
- 99. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 100. 1 yes 2 no 3 not tested Collected cells, before purging

101. Other molecular technique

- 1 yes
- 2 no

102. Specify method: _____

Specify site(s):

- 103. 1 yes 2 no 3 not tested Circulating blood cells
- 104. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 105. 1 yes 2 no 3 not tested Collected cells, before purging

106. Immunohistochemistry

- 1 yes
- 2 no

Specify site(s):

- 107. 1 yes 2 no 3 not tested Circulating blood cells
- 108. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 109. 1 yes 2 no 3 not tested Collected cells, before purging

110. Cell culture technique

- 1 yes
- 2 no

Specify site(s):

- 111. 1 yes 2 no 3 not tested Circulating blood cells
- 112. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 113. 1 yes 2 no 3 not tested Collected cells, before purging

114. Other technique

- 1 yes
- 2 no

115. Specify method: _____

Specify site(s):

- 116. 1 yes 2 no 3 not tested Circulating blood cells
- 117. 1 yes 2 no 3 not tested Bone marrow, in the interval between last systemic therapy and collection
- 118. 1 yes 2 no 3 not tested Collected cells, before purging

CIBMTR Center Number:

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119. Was the product treated to remove malignant cells (purged)? (*autologous product only*)

- 1 yes
2 no

Specify method(s) used:

120. 1 yes 2 no Monoclonal antibody → 121. If yes, specify:

122. 1 yes 2 no 4-hydroperoxycyclophosphamide (4HC)

123. 1 yes 2 no Mafosfamide

124. 1 yes 2 no Other drug → 125. If yes, specify:

126. 1 yes 2 no Elutriation

127. 1 yes 2 no Immunomagnetic column

128. 1 yes 2 no Toxin → 129. If yes, specify:

130. 1 yes 2 no Positive stem cell selection
(other than preparation
of mononuclear
fraction) →

131. If yes, specify method:

132. 1 yes 2 no Other method → 133. If yes, specify:

Specify if tumor cells were detected in the graft after purging by each method used:

134. 1 yes 2 no 3 not tested Routine histopathology

135. 1 yes 2 no 3 not tested Polymerase chain reaction (PCR)

136. 1 yes 2 no 3 not tested Other molecular technique

137. 1 yes 2 no 3 not tested Immunohistochemistry

138. 1 yes 2 no 3 not tested Cell culture technique


139. 1 yes 2 no 3 not tested Other → 140. If yes, specify:

Product Analysis (All Products)

Report product analysis results under each timepoint that testing was performed. If more than two analyses were performed, copy and complete pages 7–8 for each additional analysis.

Product Analysis at 1st Timepoint


Specify the timepoint in the product preparation phase that the product was analyzed:

141. 1 product arrival
2 post-processing, pre-cryopreservation / manipulation 
3 post-thaw
4 post-manipulation
5 at infusion (final quantity infused)

Date of product analysis: 142.
Month Day Year

Total volume of product: 143.
• 1 mL
2 g

Product Analysis at 2nd Timepoint

162. 1 product arrival
2 post-processing, pre-cryopreservation / manipulation 
3 post-thaw
4 post-manipulation
5 at infusion (final quantity infused)

163.
Month Day Year

164.
• 1 mL
2 g

CIBMTR Center Number:

CIBMTR Recipient ID:

Product Analysis at 1st Timepoint

Product Analysis at 2nd Timepoint

In this section, report the total number of cells (not cells per kilogram).

	Total Number	Exponent		Total Number	Exponent	
Nucleated cells:	144. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	165. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Mononucleated cells:	145. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	166. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Nucleated red blood cells:	146. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	167. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD34+ cells:	147. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	168. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD3+ cells:	148. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	169. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD4+ cells:	149. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	170. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
CD8+ cells:	150. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested	171. <input type="text"/>	<input type="text"/> x 10 <input type="text"/>	<input type="checkbox"/> not tested
Viability of cells:	151. <input type="text"/>	%	<input type="checkbox"/> not tested	172. <input type="text"/>	%	<input type="checkbox"/> not tested
Method of testing cell viability:	152. 1 <input type="checkbox"/> 7-AAD 2 <input type="checkbox"/> propidium iodide 3 <input type="checkbox"/> trypan blue 4 <input type="checkbox"/> other method			173. 1 <input type="checkbox"/> 7-AAD 2 <input type="checkbox"/> propidium iodide 3 <input type="checkbox"/> trypan blue 4 <input type="checkbox"/> other method		
Specify other method:	153. _____			174. _____		
Were the colony-forming units (CFU) assessed after thawing? <i>(cord blood product only)</i>	154. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 155 Continue with question 158		175. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 176 Continue with question 179	
Was there growth?	155. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no			176. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no		
Total colonies per product:	156. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown	177. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown
Total CFU-GM:	157. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown	178. <input type="text"/>	<input type="text"/> x 10 ⁵	<input type="checkbox"/> unknown
Were cultures performed before infusion to test the product(s) for bacterial or fungal infection? <i>(complete for all cell products)</i>	158. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 159 Continue with question 162		179. 1 <input type="checkbox"/> yes → 2 <input type="checkbox"/> no →	Continue with question 180 Continue with question 183	
Specify results:	159. 1 <input type="checkbox"/> positive 2 <input type="checkbox"/> negative 3 <input type="checkbox"/> unknown			180. 1 <input type="checkbox"/> positive 2 <input type="checkbox"/> negative 3 <input type="checkbox"/> unknown		
Specify organism code(s): <i>(see page 9 for codes)</i>	160. <input type="text"/>	<input type="text"/>	<input type="text"/>	181. <input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
If code 198, 209, 219, or 259, specify organism:	161. _____			182. _____		

CIBMTR Center Number:

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Codes for Commonly Reported Organisms

Bacterial Infections			Fungal Infections
121 Acinetobacter	139 Fusobacterium	155 Proteus	200 Candida, NOS
122 Actinomyces	144 Haemophilus (all species, including influenzae)	156 Pseudomonas (all species except cepacia & maltophilia)	201 Candida albicans
123 Bacillus	145 Helicobacter pylori	157 Pseudomonas or Burkholderia cepacia	206 Candida guilliermondii
124 Bacteroides (gracillis, uniformis, vulgaris, other species)	146 Klebsiella	158 Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia	202 Candida krusei
125 Bordetella pertussis (whooping cough)	147 Lactobacillus (bulgaricus, acidophilus, other species)	159 Rhodococcus	207 Candida lusitanae
126 Borrelia (Lyme disease)	102 Legionella	107 Rickettsia	203 Candida parapsilosis
127 Branhamella or Moraxella catarrhalis (other species)	103 Leptospira	160 Salmonella (all species)	204 Candida tropicalis
128 Campylobacter (all species)	148 Leptotrichia buccalis	161 Serratia marcescens	205 Candida (Torulopsis) glabrata
129 Capnocytophaga	149 Leuconostoc (all species)	162 Shigella	209 Other Candida, specify ‡
171 Chlamydia pneumoniae	104 Listeria	163 Staphylococcus, coagulase negative (not aureus)	210 Aspergillus, NOS
172 Other chlamydia, specify	150 Methylobacterium	164 Staphylococcus aureus	211 Aspergillus flavus
113 Chlamydia, NOS	151 Micrococcus, NOS	165 Staphylococcus, NOS	212 Aspergillus fumigatus
130 Citrobacter (freundii, other species)	112 Mycobacterium avium–intracellulare (MAC, MAI)	166 Stomatococcus mucilaginosus	213 Aspergillus niger
131 Clostridium (all species except difficile)	174 Mycobacterium species (chelonae, fortuitum, haemophilum, kansasii, mucogenicum)	167 Streptococcus (all species except Enterococcus)	219 Other Aspergillus, specify ‡
132 Clostridium difficile	110 Mycobacterium tuberculosis (tuberculosis, Koch bacillus)	168 Treponema (syphilis)	220 Cryptococcus species
173 Corynebacterium jeikeium	175 Other mycobacterium, specify	169 Vibrio (all species)	230 Fusarium species
133 Corynebacterium (all non-diphtheria species)	176 Mycobacterium, NOS	197 Multiple bacteria at a single site, specify bacterial codes	261 Histoplasmosis
101 Coxiella	105 Mycoplasma	198 Other bacteria, specify ‡	240 Zygomycetes, NOS
134 Enterobacter	152 Neisseria (gonorrhoea, meningitidis, other species)	501 Suspected atypical bacterial infection	241 Mucormycosis
177 Enterococcus, vancomycin resistant (VRE)	106 Nocardia	502 Suspected bacterial infection	242 Rhizopus
135 Enterococcus (all species)	153 Pasteurella multocida		250 Yeast, NOS
136 Escherichia (also E. coli)	154 Propionibacterium (acnes, avidum, granulosum, other species)		259 Other fungus, specify ‡
137 Flavimonas oryzihabitans			260 Pneumocystis (PCP / PJP)
138 Flavobacterium			503 Suspected fungal infection

‡ The codes for “other organism, specify” (codes 198, 209, 219 and 259) should rarely be needed; check with your microbiology lab or HSCT physician before using them.

Product Infusion

183. Was more than one product infused? (e.g., marrow and PBSC, PBSC and cord blood, two different cords, etc.)

- 1 yes
- 2 no

184. Was the product infusion described on this insert intended to produce hematopoietic engraftment?

- 1 yes
- 2 no

185. Date of this product infusion: / /

Month Day Year

186. Time product infusion initiated (24-hour clock): : 1 standard time
 2 daylight savings time

187. Time product infusion completed (24-hour clock): : 1 standard time
 2 daylight savings time

CIBMTR Center Number:

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188. Total volume of product plus additives infused: . mL

189. Specify the route of product infusion:

- 1 intravenous
- 2 intramedullary
- 3 intraperitoneal
- 4 other route of infusion

190. Specify route of infusion: _____

191. Did the volume of infused product include any added agents?

- 1 yes
- 2 no

Specify agent(s) added:

192. 1 yes 2 no ACD

193. 1 yes 2 no Albumin

194. 1 yes 2 no Antibiotic

195. 1 yes 2 no Dextran

196. 1 yes 2 no Heparin

197. 1 yes 2 no Other

198. Specify agent: _____

199. Was the entire volume of product infused?

- 1 yes
- 2 no

200. Specify what happened to the reserved portion:

- 1 discarded
- 2 cryopreserved for future use
- 3 other fate

201. Specify: _____

The following questions refer to all stem cell products except for autologous marrow or autologous PBSC products. If this HSCT used an autologous marrow or autologous PBSC product, continue with question 298.

202. Were there any adverse events or incidents associated with the stem cell infusion?

- 1 yes
- 2 no

Specify the following adverse event(s):		Required Medical Intervention?	Resolved?
	Adverse Event		
203. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Brachycardia	204. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	205. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
206. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Chest tightness / pain	207. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	208. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
209. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Chills at time of infusion	210. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	211. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
212. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Fever ≤ 103° F within 24 hours of infusion	213. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	214. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
215. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Fever > 103° F within 24 hours of infusion	216. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	217. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
218. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Gross hemoglobinuria	219. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	220. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
221. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Headache	222. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	223. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
224. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hives	225. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	226. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
227. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypertension	228. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	229. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
230. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypotension	231. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	232. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
233. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Hypoxia requiring oxygen (O ₂) support	234. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	235. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
236. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Nausea	237. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	238. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
239. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Rigors, mild	240. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	241. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
242. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Rigors, severe	243. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	244. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no

CIBMTR Center Number:

CIBMTR Recipient ID:

	Adverse Event	Required Medical Intervention?	Resolved?
245.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Shortness of breath (SOB)	246. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	247. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
248.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Tachycardia	249. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	250. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
251.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Vomiting	252. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	253. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
254.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other expected AE		
	255. Specify: _____	256. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	257. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
258.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other unexpected AE		
	259. Specify: _____	260. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	261. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
262.	In the Medical Director's judgement, was the adverse event a direct result of the infusion?		
	1 <input type="checkbox"/> yes		
	2 <input type="checkbox"/> no →		
	263. Specify the most likely cause of the adverse event:		
	1 <input type="checkbox"/> regimen related		
	2 <input type="checkbox"/> product reaction		
	3 <input type="checkbox"/> drug reaction		
	4 <input type="checkbox"/> other illness →		
	264. Specify illness: <input type="text"/>		
	5 <input type="checkbox"/> other reason →		
	265. Specify reason: <input type="text"/>		

Donor Demographic Information

This Donor Demographic Information section (questions 266–287) is to be completed for all stem cell donors except NMDP donors, NMDP cord blood units, and autologous marrow or PBSC donors. If the stem cell product was from an NMDP donor or an autologous marrow or PBSC donor, continue with question 298.

266. Donor's date of birth: date unknown
Month Day Year

267. (Cord blood unit only) Age of mother (approximate): years age unknown

268. (Cord blood unit only) Non-NMDP cord blood unit identification number (CBU ID):

269. (Cord blood unit only) Is the CBU ID number also the ICCBBA ISBT 128 number?
1 yes
2 no

270. (Cord blood unit only) Name of cord blood bank providing CBU: _____

271. Donor's gender:
1 male
2 female →

272. Was the donor ever pregnant?
1 yes →
2 no
3 unknown
4 not applicable, cord blood unit

273. Specify number of pregnancies: unknown

CIBMTR Center Number:

CIBMTR Recipient ID:

274. Donor's blood type and Rh factor:

- 1 A positive
- 2 A negative
- 3 B positive
- 4 B negative
- 5 AB positive
- 6 AB negative
- 7 O positive
- 8 O negative
- 9 unknown

275. Did this donor have a central line placed?

- 1 yes →
- 2 no
- 3 not applicable,
cord blood unit
or marrow product

276. Specify the site of the central line placement:

- 1 femoral
- 2 subclavian
- 3 internal jugular
- 4 other site →

277. Specify site:

278. Donor's ethnicity:

- 1 Hispanic or Latino
- 2 not Hispanic nor Latino
- 3 unknown

279. Donor's race: (Mark the group(s) in which the donor is a member. Check all that apply.) A

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 Caribbean
- 9 White South or
Central American
- 10 Other White

Black or African American

- 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 Donor declines to
provide race
- 31 Donor's race
unknown

280. What is the relationship of the donor to the recipient?

- 1 sibling
- 2 recipient's child
- 3 other relative →
- 4 unrelated

281. Specify the relationship of the donor to the recipient:

- 1 parent
- 2 aunt
- 3 uncle
- 4 cousin
- 5 other

relative → 282. Specify relationship:

CIBMTR Center Number:

CIBMTR Recipient ID:

283. Was the donor / product tested for potentially transplantable genetic diseases?

- 1 yes
- 2 no
- 3 unknown

Specify disease(s) tested:

284. 1 yes 2 no Sickle cell anemia

285. 1 yes 2 no Thalassemia

286. 1 yes 2 no Other

287. Specify genetic disease:

The following questions 288–297 apply only to allogeneic non-NMDP donors. If the stem cell product was from an autologous donor or NMDP donor, or was a cord blood unit, then continue with question 298.

288. Was the donor hospitalized (inpatient) during or after the collection?

- 1 yes
- 2 no

289. Did the donor experience any life-threatening complications during or after the collection?

- 1 yes
- 2 no

290. Specify complications:

291. Did the donor receive blood transfusions as a result of the collection?

- 1 yes
- 2 no

292. Was the blood transfusion product autologous?

- 1 yes
- 2 no

293. Specify number of units:

294. Was the blood transfusion product allogeneic (homologous)?

- 1 yes
- 2 no

295. Specify number of units:

296. Did the donor die as a result of the collection?

- 1 yes
- 2 no

297. Specify cause of death:

298. (Related donors only) Did the recipient submit a research sample?

- 1 yes
- 2 no

299. Research sample recipient ID:

300. (Related donors only) Did the donor submit a research sample?

- 1 yes
- 2 no

301. Research sample donor ID:

302. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____



Confirmation of HLA Typing

Registry Use Only

Sequence
Number:

Date
Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Non-NMDP Donor ID: *

Non-NMDP Cord Blood Unit ID: *

* See page 5 for additional ID boxes or donor date of birth and gender.

Today's Date: / /
Month Day Year

Date of HSCT for which this form is
being completed: / /
Month Day Year

HSCT type: allogeneic, unrelated allogeneic, related syngeneic (identical twin)

Product type: marrow PBSC cord blood other product, specify: _____

This form must be completed for all non-NMDP allogeneic or syngeneic donors or recipients, or non-NMDP cord blood units. If the donor, recipient, or cord blood unit was secured through the NMDP, then report HLA typing on the appropriate NMDP forms.

A separate copy of this form should be completed for each non-NMDP donor, recipient, or cord blood unit.

1. Please specify the person for whom this typing is being done:

- 1 recipient — final typing
- 2 recipient's mother — confirmatory typing →
- 3 recipient's father — confirmatory typing →
- 4 donor — confirmatory typing
- 5 cord blood unit — confirmatory typing
- 6 maternal HLA typing
- 7 other →

2. Was the recipient's mother used as the donor?

- 1 yes
- 2 no

3. Was the recipient's father used as the donor?

- 1 yes
- 2 no

4. Specify person and typing: _____

HLA Typing by DNA Technology

Six sets of boxes are provided for reporting several possible alleles for each allele at a locus. If the laboratory reports more than six possible alleles, report six of the alleles in the boxes provided and write the remainder of the alleles in the space above or below the boxes for that locus.

5. Is a copy of the lab report attached?

- 1 yes
- 2 no

CIBMTR Center Number:

CIBMTR Recipient ID:

Class I

Locus	No. of Alleles Provided		Allele Designations					
6. A	1 <input type="checkbox"/> one	First A*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> not tested	Second A*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. B	1 <input type="checkbox"/> one	First B*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> not tested	Second B*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. C	1 <input type="checkbox"/> one	First C*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> not tested	Second C*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Class II

Locus	No. of Alleles Provided		Allele Designations					
9. DRB1	1 <input type="checkbox"/> one	First DRB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> not tested	Second DRB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Class II (Optional)

Please provide the optional allele information if it is available from your laboratory.

Locus	No. of Alleles Provided		Allele Designations					
10. DRB3	1 <input type="checkbox"/> one	First DRB3*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> none		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	4 <input type="checkbox"/> not tested	Second DRB3*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11. DRB4	1 <input type="checkbox"/> one	First DRB4*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> none		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	4 <input type="checkbox"/> not tested	Second DRB4*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CIBMTR Center Number:

CIBMTR Recipient ID:

Class II (Optional)

Locus	No. of Alleles Provided		Allele Designations		
12. DRB5	1 <input type="checkbox"/> one	First DRB5*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>
	3 <input type="checkbox"/> none	Second DRB5*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	4 <input type="checkbox"/> not tested		<input type="text"/>	<input type="text"/>	<input type="text"/>
13. DQB1	1 <input type="checkbox"/> one	First DQB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second DQB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<input type="text"/>	<input type="text"/>	<input type="text"/>
14. DPB1	1 <input type="checkbox"/> one	First DPB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second DPB1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<input type="text"/>	<input type="text"/>	<input type="text"/>
15. DQA1	1 <input type="checkbox"/> one	First DQA1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second DQA1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<input type="text"/>	<input type="text"/>	<input type="text"/>
16. DPA1	1 <input type="checkbox"/> one	First DPA1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
	2 <input type="checkbox"/> two		<input type="text"/>	<input type="text"/>	<input type="text"/>
		Second DPA1*	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<input type="text"/>	<input type="text"/>	<input type="text"/>

CIBMTR Center Number:

CIBMTR Recipient ID:

Antigens Defined by Serologic Typing

Use the following lists when reporting HLA-A and B antigens. Report broad antigens only when your laboratory was not able to confirm typing for a known split antigen.

A Antigens		
6. No. of antigens provided:		
1 <input type="checkbox"/> one 2 <input type="checkbox"/> two		
Specificity	Antigen	
	1st	2nd
A1	<input type="checkbox"/>	01 <input type="checkbox"/>
A2	<input type="checkbox"/>	02 <input type="checkbox"/>
A203	<input type="checkbox"/>	03 <input type="checkbox"/>
A210	<input type="checkbox"/>	04 <input type="checkbox"/>
A3	<input type="checkbox"/>	05 <input type="checkbox"/>
A9	<input type="checkbox"/>	06 <input type="checkbox"/>
A10	<input type="checkbox"/>	07 <input type="checkbox"/>
A11	<input type="checkbox"/>	08 <input type="checkbox"/>
A19	<input type="checkbox"/>	09 <input type="checkbox"/>
A23(9)	<input type="checkbox"/>	10 <input type="checkbox"/>
A24(9)	<input type="checkbox"/>	11 <input type="checkbox"/>
A2403	<input type="checkbox"/>	12 <input type="checkbox"/>
A25(10)	<input type="checkbox"/>	13 <input type="checkbox"/>
A26(10)	<input type="checkbox"/>	14 <input type="checkbox"/>
A28	<input type="checkbox"/>	15 <input type="checkbox"/>
A29(19)	<input type="checkbox"/>	16 <input type="checkbox"/>
A30(19)	<input type="checkbox"/>	17 <input type="checkbox"/>
A31(19)	<input type="checkbox"/>	18 <input type="checkbox"/>
A32(19)	<input type="checkbox"/>	19 <input type="checkbox"/>
A33(19)	<input type="checkbox"/>	20 <input type="checkbox"/>
A34(10)	<input type="checkbox"/>	21 <input type="checkbox"/>
A36	<input type="checkbox"/>	22 <input type="checkbox"/>
A43	<input type="checkbox"/>	23 <input type="checkbox"/>
A66(10)	<input type="checkbox"/>	24 <input type="checkbox"/>
A68(28)	<input type="checkbox"/>	25 <input type="checkbox"/>
A69(28)	<input type="checkbox"/>	26 <input type="checkbox"/>
A74(19)	<input type="checkbox"/>	27 <input type="checkbox"/>
A80	<input type="checkbox"/>	28 <input type="checkbox"/>
AX	<input type="checkbox"/>	99 <input type="checkbox"/>

B Antigens								
7. Number of antigens provided:								
1 <input type="checkbox"/> one 2 <input type="checkbox"/> two								
Specificity	Antigen		Specificity	Antigen		Specificity	Antigen	
	1st	2nd		1st	2nd		1st	2nd
B5	<input type="checkbox"/>	01 <input type="checkbox"/>	B40	<input type="checkbox"/>	21 <input type="checkbox"/>	B59	<input type="checkbox"/>	42 <input type="checkbox"/>
B7	<input type="checkbox"/>	02 <input type="checkbox"/>	B4005	<input type="checkbox"/>	22 <input type="checkbox"/>	B60(40)	<input type="checkbox"/>	43 <input type="checkbox"/>
B703	<input type="checkbox"/>	03 <input type="checkbox"/>	B41	<input type="checkbox"/>	23 <input type="checkbox"/>	B61(40)	<input type="checkbox"/>	44 <input type="checkbox"/>
B8	<input type="checkbox"/>	04 <input type="checkbox"/>	B42	<input type="checkbox"/>	24 <input type="checkbox"/>	B62(15)	<input type="checkbox"/>	45 <input type="checkbox"/>
B12	<input type="checkbox"/>	05 <input type="checkbox"/>	B44(12)	<input type="checkbox"/>	25 <input type="checkbox"/>	B63(15)	<input type="checkbox"/>	46 <input type="checkbox"/>
B13	<input type="checkbox"/>	06 <input type="checkbox"/>	B45(12)	<input type="checkbox"/>	26 <input type="checkbox"/>	B64(14)	<input type="checkbox"/>	47 <input type="checkbox"/>
B14	<input type="checkbox"/>	07 <input type="checkbox"/>	B46	<input type="checkbox"/>	27 <input type="checkbox"/>	B65(14)	<input type="checkbox"/>	48 <input type="checkbox"/>
B15	<input type="checkbox"/>	08 <input type="checkbox"/>	B47	<input type="checkbox"/>	28 <input type="checkbox"/>	B67	<input type="checkbox"/>	49 <input type="checkbox"/>
B16	<input type="checkbox"/>	09 <input type="checkbox"/>	B48	<input type="checkbox"/>	29 <input type="checkbox"/>	B70	<input type="checkbox"/>	50 <input type="checkbox"/>
B17	<input type="checkbox"/>	10 <input type="checkbox"/>	B49(21)	<input type="checkbox"/>	30 <input type="checkbox"/>	B71(70)	<input type="checkbox"/>	51 <input type="checkbox"/>
B18	<input type="checkbox"/>	11 <input type="checkbox"/>	B50(21)	<input type="checkbox"/>	31 <input type="checkbox"/>	B72(70)	<input type="checkbox"/>	52 <input type="checkbox"/>
B21	<input type="checkbox"/>	12 <input type="checkbox"/>	B51(5)	<input type="checkbox"/>	32 <input type="checkbox"/>	B73	<input type="checkbox"/>	53 <input type="checkbox"/>
B22	<input type="checkbox"/>	13 <input type="checkbox"/>	B5102	<input type="checkbox"/>	33 <input type="checkbox"/>	B75(15)	<input type="checkbox"/>	54 <input type="checkbox"/>
B27	<input type="checkbox"/>	14 <input type="checkbox"/>	B5103	<input type="checkbox"/>	34 <input type="checkbox"/>	B76(15)	<input type="checkbox"/>	55 <input type="checkbox"/>
B2708	<input type="checkbox"/>	59 <input type="checkbox"/>	B52(5)	<input type="checkbox"/>	35 <input type="checkbox"/>	B77(15)	<input type="checkbox"/>	56 <input type="checkbox"/>
B35	<input type="checkbox"/>	15 <input type="checkbox"/>	B53	<input type="checkbox"/>	36 <input type="checkbox"/>	B78	<input type="checkbox"/>	57 <input type="checkbox"/>
B37	<input type="checkbox"/>	16 <input type="checkbox"/>	B54(22)	<input type="checkbox"/>	37 <input type="checkbox"/>	B81	<input type="checkbox"/>	58 <input type="checkbox"/>
B38(16)	<input type="checkbox"/>	17 <input type="checkbox"/>	B55(22)	<input type="checkbox"/>	38 <input type="checkbox"/>	B82	<input type="checkbox"/>	60 <input type="checkbox"/>
B39(16)	<input type="checkbox"/>	18 <input type="checkbox"/>	B56(22)	<input type="checkbox"/>	39 <input type="checkbox"/>	BX	<input type="checkbox"/>	99 <input type="checkbox"/>
B3901	<input type="checkbox"/>	19 <input type="checkbox"/>	B57(17)	<input type="checkbox"/>	40 <input type="checkbox"/>			
B3902	<input type="checkbox"/>	20 <input type="checkbox"/>	B58(17)	<input type="checkbox"/>	41 <input type="checkbox"/>			

CIBMTR Center Number:

CIBMTR Recipient ID:

Optional Antigen Reporting

Please provide the following optional antigen information if it is available from your laboratory. This information will be entered into the NMDP Registry and be available for future patient searches.

Antigens Defined by Serologic Typing

C Antigens		
8. No. of antigens provided: 1 <input type="checkbox"/> one 2 <input type="checkbox"/> two		
Antigen		
Specificity	1st	2nd
Cw1	<input type="checkbox"/>	01 <input type="checkbox"/>
Cw2	<input type="checkbox"/>	02 <input type="checkbox"/>
Cw3	<input type="checkbox"/>	03 <input type="checkbox"/>
Cw4	<input type="checkbox"/>	04 <input type="checkbox"/>
Cw5	<input type="checkbox"/>	05 <input type="checkbox"/>
Cw6	<input type="checkbox"/>	06 <input type="checkbox"/>
Cw7	<input type="checkbox"/>	07 <input type="checkbox"/>
Cw8	<input type="checkbox"/>	08 <input type="checkbox"/>
Cw9(w3)	<input type="checkbox"/>	09 <input type="checkbox"/>
Cw10(w3)	<input type="checkbox"/>	10 <input type="checkbox"/>
CX	<input type="checkbox"/>	99 <input type="checkbox"/>

Bw Specificity		
Specificity	Present?	
9. Bw4	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
10. Bw6	3 <input type="checkbox"/> yes	4 <input type="checkbox"/> no

DR Antigens		
11. No. of antigens provided: 1 <input type="checkbox"/> one 2 <input type="checkbox"/> two		
Antigen		
Specificity	1st	2nd
DR1	<input type="checkbox"/>	01 <input type="checkbox"/>
DR103	<input type="checkbox"/>	02 <input type="checkbox"/>
DR2	<input type="checkbox"/>	03 <input type="checkbox"/>
DR3	<input type="checkbox"/>	04 <input type="checkbox"/>
DR4	<input type="checkbox"/>	05 <input type="checkbox"/>
DR5	<input type="checkbox"/>	06 <input type="checkbox"/>
DR6	<input type="checkbox"/>	07 <input type="checkbox"/>
DR7	<input type="checkbox"/>	08 <input type="checkbox"/>
DR8	<input type="checkbox"/>	09 <input type="checkbox"/>
DR9	<input type="checkbox"/>	10 <input type="checkbox"/>
DR10	<input type="checkbox"/>	11 <input type="checkbox"/>
DR11(5)	<input type="checkbox"/>	12 <input type="checkbox"/>
DR12(5)	<input type="checkbox"/>	13 <input type="checkbox"/>
DR13(6)	<input type="checkbox"/>	14 <input type="checkbox"/>
DR14(6)	<input type="checkbox"/>	15 <input type="checkbox"/>
DR1403	<input type="checkbox"/>	16 <input type="checkbox"/>
DR1404	<input type="checkbox"/>	17 <input type="checkbox"/>
DR15(2)	<input type="checkbox"/>	18 <input type="checkbox"/>
DR16(2)	<input type="checkbox"/>	19 <input type="checkbox"/>
DR17(3)	<input type="checkbox"/>	20 <input type="checkbox"/>
DR18(3)	<input type="checkbox"/>	81 <input type="checkbox"/>
DRX	<input type="checkbox"/>	99 <input type="checkbox"/>

DR51 Antigen		
Specificity	Present?	
12. DR51	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

DR52 Antigen		
Specificity	Present?	
13. DR52	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

DR53 Antigen		
Specificity	Present?	
14. DR53	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

DQ Antigens		
15. No. of antigens provided: 1 <input type="checkbox"/> one 2 <input type="checkbox"/> two		
Antigen		
Specificity	1st	2nd
DQ1	<input type="checkbox"/>	01 <input type="checkbox"/>
DQ2	<input type="checkbox"/>	02 <input type="checkbox"/>
DQ3	<input type="checkbox"/>	03 <input type="checkbox"/>
DQ4	<input type="checkbox"/>	04 <input type="checkbox"/>
DQ5(1)	<input type="checkbox"/>	05 <input type="checkbox"/>
DQ6(1)	<input type="checkbox"/>	06 <input type="checkbox"/>
DQ7(3)	<input type="checkbox"/>	07 <input type="checkbox"/>
DQ8(3)	<input type="checkbox"/>	08 <input type="checkbox"/>
DQ9(3)	<input type="checkbox"/>	09 <input type="checkbox"/>
DQX	<input type="checkbox"/>	99 <input type="checkbox"/>

DP Antigens		
16. No. of antigens provided: 1 <input type="checkbox"/> one 2 <input type="checkbox"/> two		
Antigen		
Specificity	1st	2nd
DPw1	<input type="checkbox"/>	01 <input type="checkbox"/>
DPw2	<input type="checkbox"/>	02 <input type="checkbox"/>
DPw3	<input type="checkbox"/>	03 <input type="checkbox"/>
DPw4	<input type="checkbox"/>	04 <input type="checkbox"/>
DPw5	<input type="checkbox"/>	05 <input type="checkbox"/>
DPw6	<input type="checkbox"/>	06 <input type="checkbox"/>
DPX	<input type="checkbox"/>	99 <input type="checkbox"/>

17. Signed: _____
Person completing form
 Please print name: _____
 Phone number: (_____) _____ Fax number: (_____) _____
 E-mail address: _____

Continued from page 1

If multiple cord blood units were infused, record each of the non-NMDP cord blood unit identification numbers below:

Non-NMDP Cord Blood Unit ID:

Non-NMDP Cord Blood Unit ID:

If non-NMDP donors were used, record the identification number and/or gender and date of birth for each donor below:

Non-NMDP Donor ID: — OR — Donor gender: 1 male 2 female Donor date of birth:
 Month Day Year

Non-NMDP Donor ID: — OR — Donor gender: 1 male 2 female Donor date of birth:
 Month Day Year



Infectious Disease Markers

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Non-NMDP Donor ID: *

Non-NMDP Cord Blood Unit ID: *

* See page 3 for additional ID boxes or donor date of birth and gender.

Today's Date: / /
Month Day Year

Date of HSCT for which this form is being completed: / /
Month Day Year

HSCT type: allogeneic, unrelated allogeneic, related syngeneic (identical twin)

Product type: marrow PBSC cord blood other product, specify: _____

This form must be completed for all non-NMDP allogeneic or syngeneic donors, or non-NMDP cord blood units. If the donor or cord blood unit was secured through the NMDP, then report IDMs on forms 24 and 50 for allogeneic donors or through CORD Link for cord blood units.

1. Who is being tested for IDMs?
- 1 donor IDM (marrow or PBSC)
 - 2 maternal IDM (cord blood)
 - 3 cord blood unit IDM

Infectious Disease Marker *(report final test results)*

Test Date

Hepatitis B Virus (HBV)

2. HBsAg: (hepatitis B surface antigen)
- 1 reactive
 - 2 non-reactive
 - 3 testing not performed

3. / /
Month Day Year

4. Anti HBc: (hepatitis B core antibody) *(no confirmatory test available)*
- 1 reactive
 - 2 non-reactive
 - 3 testing not performed

5. / /
Month Day Year

Hepatitis C Virus (HCV)

6. Anti-HCV: (hepatitis C antibody)
- 1 reactive
 - 2 non-reactive
 - 3 testing not performed

7. / /
Month Day Year

Human T-Lymphotropic Virus

8. Anti-HTLV I / II:
- 1 reactive
 - 2 non-reactive
 - 3 testing not performed

9. / /
Month Day Year

Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

CIBMTR Center Number:

CIBMTR Recipient ID:

Infectious Disease Marker (report final test results)

Test Date

Human Immunodeficiency Virus (HIV)

10. HIV-1 p24 antigen:

- 1 reactive
- 2 non-reactive
- 3 not reported
- 4 not performed; HIV NAT testing performed (skip date)

11.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

12. Was FDA licensed NAT testing for HIV-1 / HCV performed?

- 1 yes →
- 2 no

Specify results:

13. HIV-1 14.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

- 1 positive
- 2 negative
- 3 not reported

15. HCV 16.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

- 1 positive
- 2 negative

17. Anti-HIV 1 and anti-HIV 2*:

(antibodies to Human Immunodeficiency Viruses)

* Testing for both HIV antibodies is required. This testing may be performed as separate tests or done using a combined assay.

- 1 reactive
- 2 non-reactive
- 3 testing not performed
- 4 not reported

18.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

Syphilis

19. STS:

- 1 reactive
- 2 non-reactive
- 3 testing not performed

20.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

Cytomegalovirus (CMV)

21. Anti-CMV: (IgG or Total)

- 1 reactive
- 2 non-reactive
- 3 previously reported reactive, not tested (skip date)
- 4 testing not performed

22.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

West Nile Virus (WNV)

23. WNV-NAT testing:

- 1 positive
- 2 negative
- 3 testing not performed
- 4 not applicable

24.

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

25. Other infectious disease marker, specify (e.g., EBV):

- 1 yes →
- 2 no

26. Specify date performed:

Month	Day	Year
<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>

27. Specify test and method: _____

28. Specify test results: _____

CIBMTR Center Number:

CIBMTR Recipient ID:

Infectious Disease Marker *(report final test results)*

Test Date

29. Other infectious disease marker, specify (e.g., EBV):

Month Day Year

- 1 yes
- 2 no

30. Specify date performed:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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31. Specify test and method: _____

32. Specify test results: _____

33. Other infectious disease marker, specify (e.g., EBV):

- 1 yes
- 2 no

34. Specify date performed:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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35. Specify test and method: _____

36. Specify test results: _____

37. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____

Continued from page 1

If multiple cord blood units were infused, record each of the non-NMDP cord blood unit identification numbers below:

Non-NMDP Cord Blood Unit ID:

Non-NMDP Cord Blood Unit ID:

If non-NMDP donors were used, record the identification number and/or gender and date of birth for each donor below:

Non-NMDP donor ID:

— OR —

Donor gender: male
 female

Donor date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year			

Non-NMDP donor ID:

— OR —

Donor gender: male
 female

Donor date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year			