OMB No: 0915-0310
Expiration Date: 10-31-2010

CIBMTR
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Hematopoietic Stem Cell Transplant (HSCT) Infusion

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number: ☐☐☐☐☐

OMB No: 0915-0310
Expiration Date: 10/31/2010

CIBMTR Recipient ID: ☐☐☐☐☐☐☐☐☐☐

Specify donor:

1 ☐ autologous

2 ☐ NMDP unrelated cord blood unit → NMDP Cord Blood Unit ID: ☐☐☐☐☐☐☐☐☐☐

3 ☐ NMDP unrelated donor → NMDP Donor ID: ☐☐☐☐-☐☐☐☐-☐

4 ☐ related donor →

5 ☐ non-NMDP unrelated donor →

6 ☐ non-NMDP cord blood unit → (include related and autologous CBUs)

Donor's / infant's date of birth: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Donor's / infant's gender: 1 ☐ male 2 ☐ female

Non-NMDP unrelated donor / cord blood unit ID: *(not applicable for related donor)*

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Is the CBU ID also the ICCBBA ISBT 128 number? 1 ☐ yes 2 ☐ no

Registry or UCB Bank ID: ☐☐☐☐

Specify other Registry or UCB Bank: _____

Mother's age at donation: ☐☐ years ☐ age unknown

Today's Date: ☐☐ Month ☐☐ Day 2 0☐☐ Year

Date of HSCT for which this form is being completed: 🕮 ☐☐ Month ☐☐ Day 2 0☐☐ Year

HSCT type: *(check only one)* ☐ autologous ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: *(check only one)* ☐ marrow ☐ PBSC ☐ cord blood ☐ other product, specify: _____

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; 🕮A indicates an appendix.

A series of collections should be considered a <u>single product</u> 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.

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

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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.)

1 ☐ yes → Specify treatment(s): *(select all that apply)*
2 ☐ no
3 ☐ NMDP donor → **Continue with question 20**
4 ☐ cord blood unit → **Continue with question 20**

2. 1 ☐ yes 2 ☐ no *(autologous only)* Chemotherapy → **Report details on disease-specific insert**
3. 1 ☐ yes 2 ☐ no *(autologous only)* Anti-CD20 (rituximab, Rituxan) → **Report details on disease-specific insert**
4. 1 ☐ yes 2 ☐ no Growth factor(s) → If yes, specify growth factor(s):
   5. 1 ☐ yes 2 ☐ no G-CSF
   6. 1 ☐ yes 2 ☐ no GM-CSF
   7. 1 ☐ yes 2 ☐ no Other → 8. Specify: _____
9. 1 ☐ yes 2 ☐ no Other treatment → 10. Specify treatment: _____

Product Collection

11. Date of product collection: ☐☐ Month ☐☐ Day 2 0 ☐☐ 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 → Specify anticoagulant(s):
2 ☐ no

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 → 19. Specify other anticoagulant: _____
    2 ☐ no

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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 | 2 0 Year

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

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: Month | Day | 2 0 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: | |

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37. Date thawing process initiated: Month | Day | 2 0 | | Year

38. Time at initiation of thaw (24-hour clock): Hour : Minute
1 ☐ standard time
2 ☐ daylight savings time

39. Time at completion of thaw (24-hour clock): Hour : Minute
1 ☐ standard time
2 ☐ daylight savings time

40. Was the primary container (e.g., cord blood unit bag) intact upon thawing?
1 ☐ yes
2 ☐ no

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 reconsituted 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 other method: _____

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

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57. CD34+ selection 🕮
1 ☐ yes → 58. Specify manufacturer:
2 ☐ no 1 ☐ CliniMACS / CliniMax
2 ☐ Isolex
3 ☐ other → 59. Specify other manufacturer: _____

60. T-cell depletion
1 ☐ yes → Specify method:
2 ☐ no
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 →
Report the antibodies used for T-cell depletion at question 73.
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 → 70. Specify other method: _____

71. Other cell manipulation
1 ☐ yes → 72. Specify other cell manipulation: _____
2 ☐ no

73. Were antibodies used during product manipulation?
1 ☐ yes → Specify antibodies:
2 ☐ no
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 other CD3: _____
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 other antibody: _____

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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. Immunohisto-chemistry
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

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

1 ☐ yes → Specify method(s) used:
2 ☐ no

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) 🕮

	Product Analysis at 1st Timepoint	Product Analysis at 2nd 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)	162. 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 | 2 0 Year	163. Month | Day | 2 0 Year
Total volume of product:	143. ____ • ____ 1 ☐ mL 2 ☐ g	164. ____ • ____ 1 ☐ mL 2 ☐ g

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

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Codes for Commonly Reported Organisms

Bacterial Infections

121 Acinetobacter
122 Actinomyces
123 Bacillus
124 Bacteroides (gracillis, uniformis, vulgaris, other species)
125 Bordetella pertussis (whooping cough)
126 Borrelia (Lyme disease)
127 Branhamella or Moraxella catarrhalis (other species)
128 Campylobacter (all species)
129 Capnocytophaga
171 Chlamydia pneumoniae
172 Other chlamydia, specify
113 Chlamydia, NOS
130 Citrobacter (freundii, other species)
131 Clostridium (all species except difficile)
132 Clostridium difficile
173 Corynebacterium jeikeium
133 Corynebacterium (all non-diptheria species)
101 Coxiella
134 Enterobacter
177 Enterococcus, vancomycin resistant (VRE)
135 Enterococcus (all species)
136 Escherichia (also E. coli)
137 Flavimonas oryzihabitans
138 Flavobacterium
139 Fusobacterium
144 Haemophilus (all species, including influenzae)
145 Helicobacter pylori
146 Klebsiella
147 Lactobacillus (bulgaricus, acidophilus, other species)
102 Legionella
103 Leptospira
148 Leptotrichia buccalis
149 Leuconostoc (all species)
104 Listeria
150 Methylobacterium
151 Micrococcus, NOS
112 Mycobacterium avium–intracellulare (MAC, MAI)
174 Mycobacterium species (cheloneae, fortuitum, haemophilum, kansasii, mucogenicum
110 Mycobacterium tuberculosis (tuberculosis, Koch bacillus)
175 Other mycobacterium, specify
176 Mycobacterium, NOS
105 Mycoplasma
152 Neisseria (gonorrhoea, meningitidis, other species)
106 Nocardia
153 Pasteurella multocida
154 Propionibacterium (acnes, avidum, granulosum, other species)
155 Proteus
156 Pseudomonas (all species except cepacia & maltophilia)
157 Pseudomonas or Burkholderia cepacia
158 Pseudomonas or Stenotrophomonas or Xanthomonas maltophilia
159 Rhodococcus
107 Rickettsia
160 Salmonella (all species)
161 Serratia marcescens
162 Shigella
163 Staphylococcus, coagulase negative (not aureus)
164 Staphylococcus aureus
165 Staphylococcus, NOS
166 Stomatococcus mucilaginosis
167 Streptococcus (all species except Enterococcus)
178 Streptococcus pneumoniae
168 Treponema (syphilis)
169 Vibrio (all species)
197 Multiple bacteria at a single site, specify bacterial codes
198 Other bacteria, specify ‡
501 Suspected atypical bacterial infection
502 Suspected bacterial infection

Fungal Infections

200 Candida, NOS
201 Candida albicans
206 Candida guillermondi
202 Candida krusei
207 Candida lusitaniae
203 Candida parapsilosis
204 Candida tropicalis
205 Candida (Torulopsis) glabrata
209 Other Candida, specify ‡
210 Aspergillus, NOS
211 Aspergillus flavus
212 Aspergillus fumigatus
213 Aspergillus niger
219 Other Aspergillus, specify ‡
220 Cryptococcus species
230 Fusarium species
261 Histoplasmosis
240 Zygomycetes, NOS
241 Mucormycosis
242 Rhizopus
250 Yeast, NOS
259 Other fungus, specify ‡
260 Pneumocystis (PCP / PJP)
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 → 184. Was the product infusion described on this insert intended to produce hematopoietic engraftment?

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 | 2 0 Year

186. Time product infusion initiated (24-hour clock): Hour : Minute

1 ☐ standard time
2 ☐ daylight savings time

187. Time product infusion completed (24-hour clock): Hour : Minute

1 ☐ standard time
2 ☐ daylight savings time

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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 the signature lines at question 296.

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

1 ☐ yes →
2 ☐ no

Specify the following adverse event(s):

Adverse Event	Required Medical Intervention?	Resolved?
203. 1 ☐ yes 2 ☐ no Brachycardia	204. 1 ☐ yes 2 ☐ no	205. 1 ☐ yes 2 ☐ no
206. 1 ☐ yes 2 ☐ no Chest tightness / pain	207. 1 ☐ yes 2 ☐ no	208. 1 ☐ yes 2 ☐ no
209. 1 ☐ yes 2 ☐ no Chills at time of infusion	210. 1 ☐ yes 2 ☐ no	211. 1 ☐ yes 2 ☐ no
212. 1 ☐ yes 2 ☐ no Fever ≤ 103° F within 24 hours of infusion	213. 1 ☐ yes 2 ☐ no	214. 1 ☐ yes 2 ☐ no
215. 1 ☐ yes 2 ☐ no Fever > 103° F within 24 hours of infusion	216. 1 ☐ yes 2 ☐ no	217. 1 ☐ yes 2 ☐ no
218. 1 ☐ yes 2 ☐ no Gross hemoglobinuria	219. 1 ☐ yes 2 ☐ no	220. 1 ☐ yes 2 ☐ no
221. 1 ☐ yes 2 ☐ no Headache	222. 1 ☐ yes 2 ☐ no	223. 1 ☐ yes 2 ☐ no
224. 1 ☐ yes 2 ☐ no Hives	225. 1 ☐ yes 2 ☐ no	226. 1 ☐ yes 2 ☐ no
227. 1 ☐ yes 2 ☐ no Hypertension	228. 1 ☐ yes 2 ☐ no	229. 1 ☐ yes 2 ☐ no
230. 1 ☐ yes 2 ☐ no Hypotension	231. 1 ☐ yes 2 ☐ no	232. 1 ☐ yes 2 ☐ no
233. 1 ☐ yes 2 ☐ no Hypoxia requiring oxygen (O_2) support	234. 1 ☐ yes 2 ☐ no	235. 1 ☐ yes 2 ☐ no
236. 1 ☐ yes 2 ☐ no Nausea	237. 1 ☐ yes 2 ☐ no	238. 1 ☐ yes 2 ☐ no
239. 1 ☐ yes 2 ☐ no Rigors, mild	240. 1 ☐ yes 2 ☐ no	241. 1 ☐ yes 2 ☐ no
242. 1 ☐ yes 2 ☐ no Rigors, severe	243. 1 ☐ yes 2 ☐ no	244. 1 ☐ yes 2 ☐ no

Internal use: Document number F00481 revision 2 Replaces: F00481 version 1.0 July 2007

	Adverse Event	Required Medical Intervention?	Resolved?
245. 1 ☐ yes 2 ☐ no	Shortness of breath (SOB)	246. 1 ☐ yes 2 ☐ no	247. 1 ☐ yes 2 ☐ no
248. 1 ☐ yes 2 ☐ no	Tachycardia	249. 1 ☐ yes 2 ☐ no	250. 1 ☐ yes 2 ☐ no
251. 1 ☐ yes 2 ☐ no	Vomiting	252. 1 ☐ yes 2 ☐ no	253. 1 ☐ yes 2 ☐ no
254. 1 ☐ yes 2 ☐ no	Other expected AE 255. Specify: _____	256. 1 ☐ yes 2 ☐ no	257. 1 ☐ yes 2 ☐ no
258. 1 ☐ yes 2 ☐ no	Other unexpected AE 259. Specify: _____	260. 1 ☐ yes 2 ☐ no	261. 1 ☐ yes 2 ☐ no

262. In the Medical Director's judgement, was the adverse event a direct result of the infusion?

1 ☐ yes
2 ☐ no →

263. Specify the most likely cause of the adverse event:

1 ☐ regimen related
2 ☐ product reaction
3 ☐ drug reaction
4 ☐ other illness → 264. Specify illness: _____
5 ☐ other reason → 265. Specify reason: _____

Donor / Infant Demographic Information

This Donor Demographic Information section (questions 266–281) is to be completed for all non-NMDP allogeneic donors. If the stem cell product was from an NMDP donor or an autologous marrow or PBSC donor, continue with the signature lines at question 296.

266. *(Female donor only)* Was the donor ever pregnant?

1 ☐ yes → 267. Specify number of pregnancies: | | ☐ unknown
2 ☐ no
3 ☐ unknown
4 ☐ not applicable / cord blood unit

268. 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

Internal use: Document number F00481 revision 2 Replaces: F00481 version 1.0 July 2007

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

269. Did this donor have a central line placed?

1 ☐ yes → 270. Specify the site of the central line placement:
- 1 ☐ femoral
- 2 ☐ subclavian
- 3 ☐ internal jugular
- 4 ☐ other site → 271 Specify site: _____

2 ☐ no

3 ☐ not applicable, cord blood unit or marrow product

272. Donor's ethnicity:

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

273. 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

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

1 ☐ sibling
2 ☐ recipient's child
3 ☐ other relative → 275. Specify the relationship of the donor to the recipient:
- 1 ☐ parent
- 2 ☐ aunt
- 3 ☐ uncle
- 4 ☐ cousin
- 5 ☐ other relative → 276. Specify relationship: _____

4 ☐ unrelated

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

1 ☐ yes → Specify disease(s) tested:
- 278. 1 ☐ yes 2 ☐ no Sickle cell anemia
- 279. 1 ☐ yes 2 ☐ no Thalassemia
- 280. 1 ☐ yes 2 ☐ no Other → 281. Specify genetic disease: _____

2 ☐ no

3 ☐ unknown

Internal use: Document number F00481 revision 2 Replaces: F00481 version 1.0 July 2007

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

The following questions 282–295 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 the signature lines at question 296.

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

1 ☐ yes
2 ☐ no

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

1 ☐ yes → 284. Specify complications: _____
2 ☐ no

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

1 ☐ yes →
2 ☐ no

286. Was the blood transfusion product autologous?

1 ☐ yes → 287. Specify number of units: | |
2 ☐ no

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

1 ☐ yes → 289. Specify number of units: | |
2 ☐ no

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

1 ☐ yes → 291. Specify cause of death: _____
2 ☐ no

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

1 ☐ yes → 293. Research sample recipient ID: | | | | | | | | | |
2 ☐ no

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

1 ☐ yes → 295. Research sample donor ID: | | | | | | | | | |
2 ☐ no

296. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____

Internal use: Document number F00481 revision 2 Replaces: F00481 version 1.0 July 2007

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Confirmation of HLA Typing

Registry Use Only

Sequence Number:

Date Received:

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 0915-0310. Public reporting burden for this collection of information, in combination with the IDM Form 2004 and HSCT Infusion Form 2006, is estimated to average 1.5 hours per response, 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.

CIBMTR Center Number: _____

OMB No: 0915-0310
Expiration Date: 10/31/2010

CIBMTR Recipient ID: _____

Specify non-NMDP donor:

1 ☐ related donor →
2 ☐ non-NMDP unrelated donor →
3 ☐ non-NMDP cord blood unit → (include related and autologous CBUs)

Donor's / infant's date of birth: ____ ____ ____ (Month Day Year)

Donor's / infant's gender:
1 ☐ male
2 ☐ female

Non-NMDP unrelated donor / cord blood unit ID: *(not applicable for related donor)* _____

Today's Date: ____ ____ 2 0 ____ ____ (Month Day Year)

Date of HSCT for which this form is being completed: 🕮 ____ ____ 2 0 ____ ____ (Month Day Year)

HSCT type: *(check only one)* ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: *(check only one)* ☐ 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. 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: _____

Internal use: Document number F00480 revision 3 Replaces: F00480 revision 2 June 2009

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

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

HLA Typing by DNA Technology

Space is provided for reporting several possible alleles for each allele at a locus. If more space is needed, write the remainder of the alleles in the space above or below the box for that locus. A lab report may be attached to the completed report to provide additional information or typing result clarification for the form review process at the NMDP.

5. Is a copy of the laboratory report attached?
   1 ☐ yes
   2 ☐ no

Class I

	Locus			Allele Designations
6.	A	☐ not tested	First A*	
			Second A*	
7.	B	☐ not tested	First B*	
			Second B*	
8.	C	☐ not tested	First C*	
			Second C*	

Class II

	Locus			Allele Designations
9.	DRB1	☐ not tested	First DRB1*	
			Second DRB1*	

Internal use: Document number F00480 revision 3 Replaces: F00480 revision 2 June 2009

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

Class II (Optional)

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

Locus		Allele Designations
10. DRB3 ☐ not tested	First DRB3*	
	Second DRB3*	
11. DRB4 ☐ not tested	First DRB4*	
	Second DRB4*	
12. DRB5 ☐ not tested	First DRB5*	
	Second DRB5*	
13. DQB1 ☐ not tested	First DQB1*	
	Second DQB1*	
14. DPB1 ☐ not tested	First DPB1*	
	Second DPB1*	
15. DQA1 ☐ not tested	First DQA1*	
	Second DQA1*	
16. DPA1 ☐ not tested	First DPA1*	
	Second DPA1*	

Internal use: Document number F00480 revision 3 Replaces: F00480 revision 2 June 2009

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

17. No. of antigens provided:
1 ☐ one 2 ☐ two

Specificity	Antigen 1st		Antigen 2nd
A1	☐	01	☐
A2	☐	02	☐
A203	☐	03	☐
A210	☐	04	☐
A3	☐	05	☐
A9	☐	06	☐
A10	☐	07	☐
A11	☐	08	☐
A19	☐	09	☐
A23(9)	☐	10	☐
A24(9)	☐	11	☐
A2403	☐	12	☐
A25(10)	☐	13	☐
A26(10)	☐	14	☐
A28	☐	15	☐
A29(19)	☐	16	☐
A30(19)	☐	17	☐
A31(19)	☐	18	☐
A32(19)	☐	19	☐
A33(19)	☐	20	☐
A34(10)	☐	21	☐
A36	☐	22	☐
A43	☐	23	☐
A66(10)	☐	24	☐
A68(28)	☐	25	☐
A69(28)	☐	26	☐
A74(19)	☐	27	☐
A80	☐	28	☐
AX	☐	99	☐

B Antigens

18. Number of antigens provided:
1 ☐ one 2 ☐ two

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

Internal use: Document number F00480 revision 3 Replaces: F00480 revision 2 June 2009

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

Optional Antigen Reporting

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

Antigens Defined by Serologic Typing

C Antigens

19. No. of antigens provided: 1 ☐ one 2 ☐ two

Specificity	Antigen 1st		Antigen 2nd	
Cw1	☐	01	☐	
Cw2	☐	02	☐	
Cw3	☐	03	☐	
Cw4	☐	04	☐	
Cw5	☐	05	☐	
Cw6	☐	06	☐	
Cw7	☐	07	☐	
Cw8	☐	08	☐	
Cw9(w3)	☐	09	☐	
Cw10(w3)	☐	10	☐	
CX	☐	99	☐	

Bw Specificity

Specificity	Present?
20. Bw4	1 ☐ yes 2 ☐ no
21. Bw6	1 ☐ yes 2 ☐ no

DR Antigens

22. No. of antigens provided: 1 ☐ one 2 ☐ two

Specificity	Antigen 1st		Antigen 2nd	
DR1	☐	01	☐	
DR103	☐	02	☐	
DR2	☐	03	☐	
DR3	☐	04	☐	
DR4	☐	05	☐	
DR5	☐	06	☐	
DR6	☐	07	☐	
DR7	☐	08	☐	
DR8	☐	09	☐	
DR9	☐	10	☐	
DR10	☐	11	☐	
DR11(5)	☐	12	☐	
DR12(5)	☐	13	☐	
DR13(6)	☐	14	☐	
DR14(6)	☐	15	☐	
DR1403	☐	16	☐	
DR1404	☐	17	☐	
DR15(2)	☐	18	☐	
DR16(2)	☐	19	☐	
DR17(3)	☐	20	☐	
DR18(3)	☐	81	☐	
DRX	☐	99	☐	

DR51 Antigen

Specificity	Present?
23. DR51	1 ☐ yes 2 ☐ no

DR52 Antigen

Specificity	Present?
24. DR52	1 ☐ yes 2 ☐ no

DR53 Antigen

Specificity	Present?
25. DR53	1 ☐ yes 2 ☐ no

DQ Antigens

26. No. of antigens provided: 1 ☐ one 2 ☐ two

Specificity	Antigen 1st		Antigen 2nd	
DQ1	☐	01	☐	
DQ2	☐	02	☐	
DQ3	☐	03	☐	
DQ4	☐	04	☐	
DQ5(1)	☐	05	☐	
DQ6(1)	☐	06	☐	
DQ7(3)	☐	07	☐	
DQ8(3)	☐	08	☐	
DQ9(3)	☐	09	☐	
DQX	☐	99	☐	

DP Antigens

27. No. of antigens provided: 1 ☐ one 2 ☐ two

Specificity	Antigen 1st		Antigen 2nd	
DPw1	☐	01	☐	
DPw2	☐	02	☐	
DPw3	☐	03	☐	
DPw4	☐	04	☐	
DPw5	☐	05	☐	
DPw6	☐	06	☐	
DPX	☐	99	☐	

28. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

Internal use: Document number F00480 revision 3 Replaces: F00480 revision 2 June 2009

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Infectious Disease Markers

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

OMB No: 0915-0310
Expiration Date: 10/31/2010

CIBMTR Recipient ID:

Specify non-NMDP donor:

1 ☐ related donor →
2 ☐ non-NMDP unrelated donor →
3 ☐ non-NMDP cord blood unit → (include related and autologous CBUs)

Donor's / infant's date of birth: Month Day Year

Donor's / infant's gender:
1 ☐ male
2 ☐ female

Non-NMDP unrelated donor / cord blood unit ID: *(not applicable for related donor)*

Today's Date: Month Day Year 20

Date of HSCT for which this form is being completed: 🕮 Month Day Year 20

HSCT type: *(check only one)* ☐ allogeneic, unrelated ☐ allogeneic, related ☐ syngeneic (identical twin)

Product type: *(check only one)* ☐ 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 (Month / Day / Year)

Hepatitis B Virus (HBV)

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

3. Test Date: Month Day Year 20

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

5. Test Date: Month Day Year 20

Hepatitis C Virus (HCV)

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

7. Test Date: Month Day Year 20

Internal use: Document number F00479 revision 2 Replaces: F00479 version 1.0 July 2007

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 — Month / Day / Year

Human T-Lymphotropic Virus

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

9. Test Date: Month | | Day | | Year 2 0 | |

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. Test Date: Month | | Day | | Year 2 0 | |

12. Was FDA licensed NAT testing for HIV-1 / HCV performed?
    - 1 ☐ yes →
    - 2 ☐ no

Specify results:

13. HIV-1
    - 1 ☐ positive
    - 2 ☐ negative
    - 3 ☐ not reported

14. Test Date: Month | | Day | | Year 2 0 | |

15. HCV
    - 1 ☐ positive
    - 2 ☐ negative

16. Test Date: Month | | Day | | Year 2 0 | |

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. Test Date: Month | | Day | | Year 2 0 | |

Syphilis

19. STS:
    - 1 ☐ reactive
    - 2 ☐ non-reactive
    - 3 ☐ testing not performed

20. Test Date: Month | | Day | | Year 2 0 | |

Cytomegalovirus (CMV)

21. Anti-CMV: (IgG or Total)
    - 1 ☐ reactive
    - 2 ☐ non-reactive
    - 3 ☐ testing not performed

22. Test Date: Month | | Day | | Year 2 0 | |

Internal use: Document number F00479 revision 2 Replaces: F00479 version 1.0 July 2007

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

Infectious Disease Marker *(report final test results)*

Test Date

West Nile Virus (WNV)

Month Day Year

23. WNV-NAT testing:
    1 ☐ positive
    2 ☐ negative
    3 ☐ testing not performed
    4 ☐ not applicable

24. | | | | | 2 | 0 | | |

25. Other infectious disease marker, specify (e.g., EBV):
    1 ☐ yes →
    2 ☐ no

    26. Specify date performed: | | | | | 2 | 0 | | |
    27. Specify test and method: _____
    28. Specify test results: _____

29. Other infectious disease marker, specify (e.g., EBV):
    1 ☐ yes →
    2 ☐ no

    30. Specify date performed: | | | | | 2 | 0 | | |
    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: | | | | | 2 | 0 | | |
    35. Specify test and method: _____
    36. Specify test results: _____

37. Signed: _____
Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____

Internal use: Document number F00479 revision 2 Replaces: F00479 version 1.0 July 2007