

Infectious Disease Markers

Registry I	Use	Only	
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Sequence Number:

OMB No: 0915-0310 Expiration Date: 12/31/2013

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 HLA Typing Form 2005 and HCT 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. Expiration date: 12/31/2013

Date Received:

CIBMTR Center Number:							
CIBMTR Recipient ID:							
Date of HCT for which this form is being completed:							
	YYYY	MM	DD				
HCT type: <i>(check only one)</i>							
\Box Allogeneic, related							
Product type: (check all that apply)							
□ Bone marrow							
D PBSC							
□ Single cord blood unit							
Other product							
Specify:							

This form must be completed for all non-NMDP allogeneic or syngeneic donors, or non-NMDP cord blood units.

Donor / Cord Blood Unit Identification

1.	Specify non-NMDP donor:							
	Related donor – Go to question 4							
	Non-NMDP unrelated donor – Go to question 2							
	□ Non-NMDP cord blood unit (include related and autologous CBUs) – <i>Go to question 3</i>							
	2.Non-NMDP unrelated donor ID: <i>(not applicable for related donor)</i> Go to question 4							
	3.Non-NMDP cord blood unit ID: <i>(include related and autologous CBUs)</i>							
4.	Date of birth (donor / infant):							
	☐ Known – Go to question 5							
	□ Unknown – Go to question 6							
	5. Date of birth (donor / infant):	estion 8						
	6. Age (donor / infant):							
	☐ Known – Go to question 7							
	Unknown – Go to question 8							
	7. Age (donor / infant):	old)						
8.	Sex (donor / infant):							
	□ Male							
	□ Female							
9.	Who is being tested for IDMs?							
	Donor IDM (bone marrow or PBSC)							
	Maternal IDM (cord blood)							
	Cord blood unit IDM							

CIBMTR Center Number: ____ ___ ___ ___

Infectious Disease Marker (report final test results)

Hepatitis B Virus (HBV)

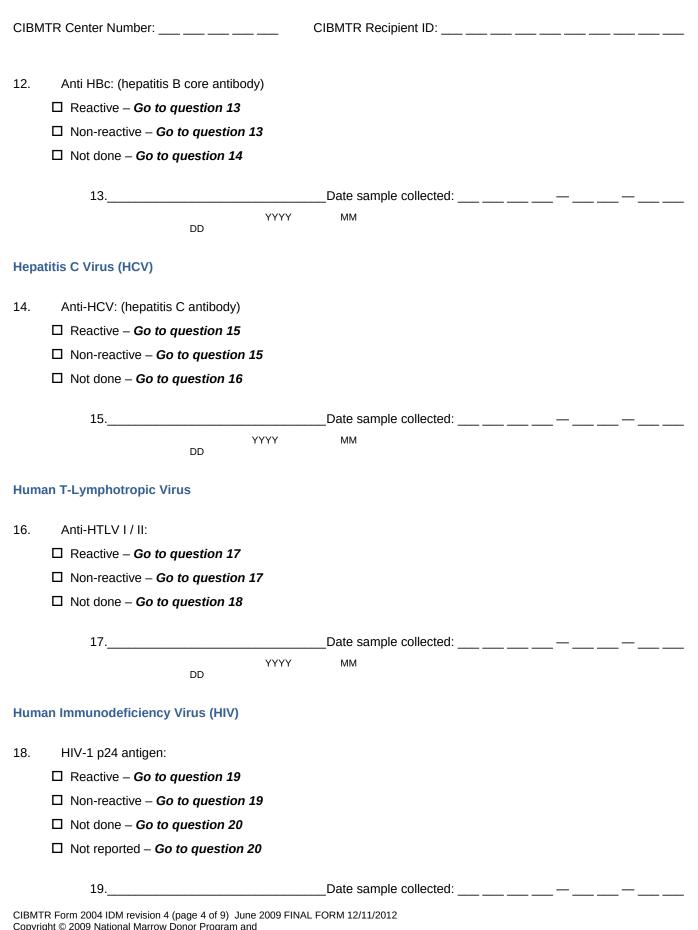
10. HBsAg: (hepatitis B surface antigen)

□ Reactive – Go to question 11

□ Non-reactive – Go to question 11

□ Not done – Go to question 12

11		Date sam	ple collected:	 	—
	YYYY	MM	DD		



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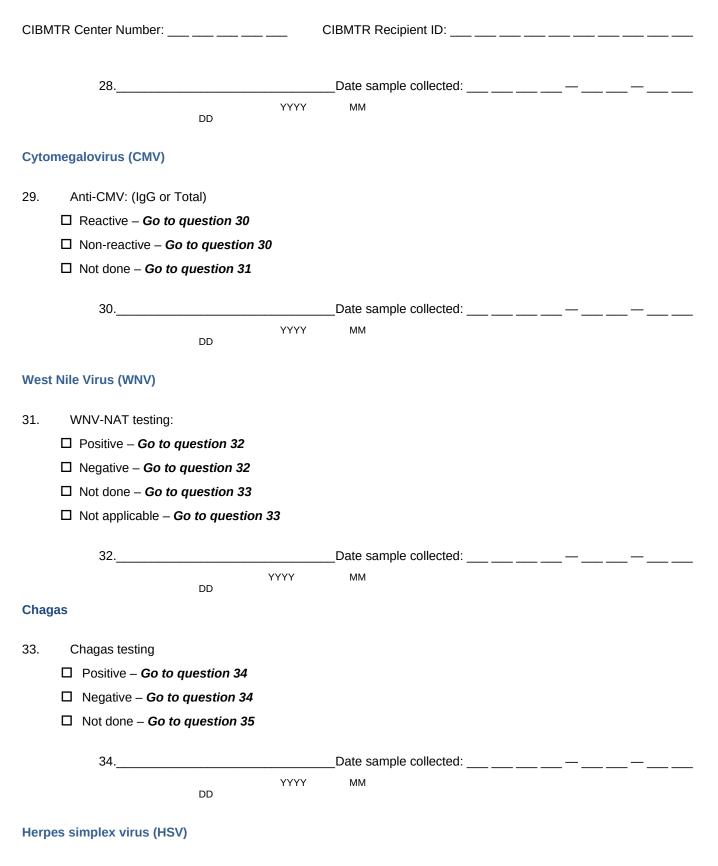
YYYY MM DD 20. Was FDA licensed NAT testing for HIV-1 / HCV performed?

□ Yes – Go to questions 21

□ No – Go to question 25

Specify results:

		21					· · · · · · · · · · · · · · · · · · ·	HIV-1	
		D Positive –	Go to questi	on 22					
		Negative – Go to question 22							
		□ Not reported	ed – Go to qu	estion 23					
	22.	Date sample of	collected:		·				
		MM	DD	YYYY					
		23						HCV	
		D Positive							
		Negative							
		24			Date samp	le collected:		·	
			DD	YYYY	ММ				
25.	* Test	i-HIV 1 and anti ng for both HIV an eactive – Go to	tibodies is requi			-	es) ests or done using a	combined assay.	
		on-reactive – G	-	26					
		ot done – Go to	-						
	ΠN	ot reported – Ge	o to question	27					
		26			Date samp	le collected:		·	
				YYYY	MM	DD			
Sypł	nilis								
27.	ST	S:							
	ΠR	eactive – Go to	question 28						
	ΠN	on-reactive – G	o to question	n 28					
	ΠN	ot done – Go to	question 29						



35. Anti-HSV (Herpes simplex virus antibody)

D Positive – *Go to question 36*

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CIBMTR Center Number:			CIBMTR Recipient ID:				
		Negative – Go to question 36					
		Not done – Go to question 37					
		36		Date sample co	ollected:		
			YYYY	MM	DD		
Epste	ein-I	Barr virus (EBV)					
37.	А	nti-EBV (Epstein–Barr virus ant	ibody)				
		Positive – Go to question 38					
		Negative – Go to question 38					
		Inconclusive - Go to question	38				
		Not done – Go to question 39	1				
		38		Date sample co	ollected:		
			YYYY	MM			
Varic	ella	zoster virus (VZV)					
39.	А	nti-VZV (Varicella zoster virus a	ntibody)				
		Positive – Go to question 40					
		Negative – Go to question 40					
		Not done – Go to question 41					
		40		Date sample co	ollected:		
			YYYY	MM	DD		
Тохо	plas	mosis					
41.	Т	oxoplasmosis					
		Positive – Go to question 42					
		Negative – Go to question 42					
		Not done – Go to question 43					
		42		Date sample co	ollected:		
			YYYY	MM	 DD		

Other Infectious Disease Marker

43. Other infectious disease marker, specify:

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CIBMTR Center Number:	C	IBMTR Recipie	ent ID:	
Yes – Go to question 44				
□ No – Go to signature line				
44		_Date sample	collected:	
	YYYY	MM	DD	
				Specify test and method:
46				Specify test results:
Copy questions 44–46 to repor	-			
First Name:				
Last Name:				
E-mail address:	· · · · · · · · · · · · · · · · · · ·			
Date:				
YYYY MM	DD			