



Pre-Transplant Essential Data

CIBMTR Use Only
Sequence Number: _____

Date Received: _____

(Request for OMB approval will be submitted when form is complete)

OMB No: 0915-0310

Expiration Date: 1/31/2020

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 is estimated to average 0.85 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: 1/31/2020

Center Identification

CIBMTR Center Number: _____

EBMT Code (CIC): _____

Recipient Identification

CIBMTR Research ID (CRID): _____

Event date: __ __ __ __ / __ __ / __ __
 YYYY MM DD

Recipient Data

1. Date of birth: ___/___/___
YYYY MM DD

2. Sex: Male Female

3. Ethnicity: Hispanic or Latino Not Hispanic or Latino Not applicable (not a resident of the USA) Unknown

4. Race: (check all that apply)

- White →
- Black or African American →
- Asian →
- American Indian or Alaska Native →
- Native Hawaiian or Other Pacific Islander →
- Not reported →
- Unknown - **Go to question 6**

5. Race detail: (check all that apply)

- Eastern European
- Mediterranean
- Middle Eastern
- North Coast of Africa
- North American
- Northern European
- Western European
- White Caribbean
- White South or Central American
- Other White
- African
- African American
- Black Caribbean
- Black South or Central American
- Other Black
- Alaskan Native or Aleut
- North American Indian
- American Indian, South or Central America
- Caribbean Indian
- South Asian
- Filipino (Pilipino)
- Japanese
- Korean
- Chinese
- Vietnamese
- Other Southeast Asian
- Guamanian
- Hawaiian
- Samoan
- Other Pacific Islander
- Unknown

6. Country of primary residence:

- | | | |
|---|--|--|
| <input type="checkbox"/> Afghanistan | <input type="checkbox"/> Chad | <input type="checkbox"/> Grenada |
| <input type="checkbox"/> Aland Islands | <input type="checkbox"/> Chile | <input type="checkbox"/> Guadeloupe |
| <input type="checkbox"/> Albania | <input type="checkbox"/> China | <input type="checkbox"/> Guam |
| <input type="checkbox"/> Algeria | <input type="checkbox"/> Christmas Island | <input type="checkbox"/> Guatemala |
| <input type="checkbox"/> American Samoa | <input type="checkbox"/> Cocos (Keeling) Islands | <input type="checkbox"/> Guernsey |
| <input type="checkbox"/> Andorra | <input type="checkbox"/> Colombia | <input type="checkbox"/> Guinea |
| <input type="checkbox"/> Angola | <input type="checkbox"/> Comoros | <input type="checkbox"/> Guinea-Bissau |
| <input type="checkbox"/> Anguilla | <input type="checkbox"/> Congo, Democratic Republic of the | <input type="checkbox"/> Guyana |
| <input type="checkbox"/> Antarctica | <input type="checkbox"/> Congo, Republic of the | <input type="checkbox"/> Haiti |
| <input type="checkbox"/> Antigua and Barbuda | <input type="checkbox"/> Cook Islands | <input type="checkbox"/> Heard Island and McDonald Islands |
| <input type="checkbox"/> Argentina | <input type="checkbox"/> Costa Rica | <input type="checkbox"/> Holy See |
| <input type="checkbox"/> Armenia | <input type="checkbox"/> Cote d'Ivoire | <input type="checkbox"/> Honduras |
| <input type="checkbox"/> Aruba | <input type="checkbox"/> Croatia | <input type="checkbox"/> Hong Kong |
| <input type="checkbox"/> Australia | <input type="checkbox"/> Cuba | <input type="checkbox"/> Hungary |
| <input type="checkbox"/> Austria | <input type="checkbox"/> Curacao | <input type="checkbox"/> Iceland |
| <input type="checkbox"/> Azerbaijan | <input type="checkbox"/> Cyprus | <input type="checkbox"/> India |
| <input type="checkbox"/> Bahamas | <input type="checkbox"/> Czech Republic | <input type="checkbox"/> Indonesia |
| <input type="checkbox"/> Bahrain | <input type="checkbox"/> Denmark | <input type="checkbox"/> Iran |
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> Djibouti | <input type="checkbox"/> Iraq |
| <input type="checkbox"/> Barbados | <input type="checkbox"/> Dominica | <input type="checkbox"/> Ireland |
| <input type="checkbox"/> Belarus | <input type="checkbox"/> Dominican Republic | <input type="checkbox"/> Isle of Man |
| <input type="checkbox"/> Belgium | <input type="checkbox"/> Ecuador | <input type="checkbox"/> Israel |
| <input type="checkbox"/> Belize | <input type="checkbox"/> Egypt | <input type="checkbox"/> Italy |
| <input type="checkbox"/> Benin | <input type="checkbox"/> El Salvador | <input type="checkbox"/> Jamaica |
| <input type="checkbox"/> Bermuda | <input type="checkbox"/> Equatorial Guinea | <input type="checkbox"/> Japan |
| <input type="checkbox"/> Bhutan | <input type="checkbox"/> Eritrea | <input type="checkbox"/> Jersey |
| <input type="checkbox"/> Bolivia | <input type="checkbox"/> Estonia | <input type="checkbox"/> Jordan |
| <input type="checkbox"/> Bonaire, Sint Eustatius and Saba | <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Kazakhstan |
| <input type="checkbox"/> Bosnia and Herzegovina | <input type="checkbox"/> Falkland Islands | <input type="checkbox"/> Kenya |
| <input type="checkbox"/> Botswana | <input type="checkbox"/> Faroe Islands | <input type="checkbox"/> Kiribati |
| <input type="checkbox"/> Bouvet Island | <input type="checkbox"/> Fiji | <input type="checkbox"/> Kuwait |
| <input type="checkbox"/> Brazil - go to question 7 | <input type="checkbox"/> Finland | <input type="checkbox"/> Kyrgyzstan |
| <input type="checkbox"/> British Indian Ocean Territory | <input type="checkbox"/> France | <input type="checkbox"/> Laos |
| <input type="checkbox"/> British Virgin Islands | <input type="checkbox"/> French Guiana | <input type="checkbox"/> Latvia |
| <input type="checkbox"/> Brunei Darussalam | <input type="checkbox"/> French Polynesia | <input type="checkbox"/> Lebanon |
| <input type="checkbox"/> Bulgaria | <input type="checkbox"/> French Southern Territories | <input type="checkbox"/> Lesotho |
| <input type="checkbox"/> Burkina Faso | <input type="checkbox"/> Gabon | <input type="checkbox"/> Liberia |
| <input type="checkbox"/> Burundi | <input type="checkbox"/> Gambia | <input type="checkbox"/> Libya |
| <input type="checkbox"/> Cambodia | <input type="checkbox"/> Georgia | <input type="checkbox"/> Liechtenstein |
| <input type="checkbox"/> Cameroon | <input type="checkbox"/> Germany | <input type="checkbox"/> Lithuania |
| <input type="checkbox"/> Canada - go to question 8 | <input type="checkbox"/> Ghana | <input type="checkbox"/> Luxembourg |
| <input type="checkbox"/> Cape Verde | <input type="checkbox"/> Gibraltar | <input type="checkbox"/> Macau |
| <input type="checkbox"/> Cayman Islands | <input type="checkbox"/> Greece | <input type="checkbox"/> Macedonia |
| <input type="checkbox"/> Central African Republic | <input type="checkbox"/> Greenland | <input type="checkbox"/> Madagascar |

CIBMTR Center Number: _____

CIBMTR Recipient ID: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Malawi | <input type="checkbox"/> Papua New Guinea | <input type="checkbox"/> Sri Lanka |
| <input type="checkbox"/> Malaysia | <input type="checkbox"/> Paraguay | <input type="checkbox"/> Sudan |
| <input type="checkbox"/> Maldives | <input type="checkbox"/> Peru | <input type="checkbox"/> Suriname |
| <input type="checkbox"/> Mali | <input type="checkbox"/> Philippines | <input type="checkbox"/> Svalbard and Jan Mayen |
| <input type="checkbox"/> Malta | <input type="checkbox"/> Pitcairn Islands | <input type="checkbox"/> Swaziland |
| <input type="checkbox"/> Marshall Islands | <input type="checkbox"/> Poland | <input type="checkbox"/> Sweden |
| <input type="checkbox"/> Martinique | <input type="checkbox"/> Portugal | <input type="checkbox"/> Switzerland |
| <input type="checkbox"/> Mauritania | <input type="checkbox"/> Puerto Rico | <input type="checkbox"/> Syria |
| <input type="checkbox"/> Mauritius | <input type="checkbox"/> Qatar | <input type="checkbox"/> Taiwan |
| <input type="checkbox"/> Mayotte | <input type="checkbox"/> Reunion | <input type="checkbox"/> Tajikistan |
| <input type="checkbox"/> Mexico | <input type="checkbox"/> Romania | <input type="checkbox"/> Tanzania |
| <input type="checkbox"/> Micronesia | <input type="checkbox"/> Russia | <input type="checkbox"/> Thailand |
| <input type="checkbox"/> Moldova | <input type="checkbox"/> Rwanda | <input type="checkbox"/> Timor-Leste |
| <input type="checkbox"/> Monaco | <input type="checkbox"/> Saint Barthelemy | <input type="checkbox"/> Togo |
| <input type="checkbox"/> Mongolia | <input type="checkbox"/> Saint Helena | <input type="checkbox"/> Tokelau |
| <input type="checkbox"/> Montenegro | <input type="checkbox"/> Saint Kitts and Nevis | <input type="checkbox"/> Tonga |
| <input type="checkbox"/> Montserrat | <input type="checkbox"/> Saint Lucia | <input type="checkbox"/> Trinidad and Tobago |
| <input type="checkbox"/> Morocco | <input type="checkbox"/> Saint Martin, French | <input type="checkbox"/> Tunisia |
| <input type="checkbox"/> Mozambique | <input type="checkbox"/> Saint Pierre and Miquelon | <input type="checkbox"/> Turkey |
| <input type="checkbox"/> Myanmar | <input type="checkbox"/> Saint Vincent and the Grenadines | <input type="checkbox"/> Turkmenistan |
| <input type="checkbox"/> Namibia | <input type="checkbox"/> Samoa | <input type="checkbox"/> Turks and Caicos Islands |
| <input type="checkbox"/> Nauru | <input type="checkbox"/> San Marino | <input type="checkbox"/> Tuvalu |
| <input type="checkbox"/> Nepal | <input type="checkbox"/> Sao Tome and Principe | <input type="checkbox"/> Uganda |
| <input type="checkbox"/> Netherlands | <input type="checkbox"/> Saudi Arabia | <input type="checkbox"/> Ukraine |
| <input type="checkbox"/> Netherlands Antilles | <input type="checkbox"/> Senegal | <input type="checkbox"/> United Arab Emirates |
| <input type="checkbox"/> New Caledonia | <input type="checkbox"/> Serbia | <input type="checkbox"/> United Kingdom (England, Wales, Scotland, Northern Ireland) |
| <input type="checkbox"/> New Zealand | <input type="checkbox"/> Seychelles | <input type="checkbox"/> United States - go to question 9 |
| <input type="checkbox"/> Nicaragua | <input type="checkbox"/> Sierra Leone | <input type="checkbox"/> United States Minor Outlying Islands |
| <input type="checkbox"/> Niger | <input type="checkbox"/> Singapore | <input type="checkbox"/> United States Virgin Islands |
| <input type="checkbox"/> Nigeria | <input type="checkbox"/> Sint Maarten, Dutch | <input type="checkbox"/> Uruguay |
| <input type="checkbox"/> Niue | <input type="checkbox"/> Slovak Republic | <input type="checkbox"/> Uzbekistan |
| <input type="checkbox"/> Norfolk Island | <input type="checkbox"/> Slovenia | <input type="checkbox"/> Vanuatu |
| <input type="checkbox"/> North Korea | <input type="checkbox"/> Solomon Islands | <input type="checkbox"/> Venezuela |
| <input type="checkbox"/> Northern Mariana Islands | <input type="checkbox"/> Somalia | <input type="checkbox"/> Vietnam |
| <input type="checkbox"/> Norway | <input type="checkbox"/> South Africa | <input type="checkbox"/> Wallis and Futuna Islands |
| <input type="checkbox"/> Oman | <input type="checkbox"/> South Georgia and the South Sandwich Islands | <input type="checkbox"/> Western Sahara |
| <input type="checkbox"/> Pakistan | <input type="checkbox"/> Islands | <input type="checkbox"/> Yemen |
| <input type="checkbox"/> Palau | <input type="checkbox"/> South Korea | <input type="checkbox"/> Zambia |
| <input type="checkbox"/> Palestine, State of | <input type="checkbox"/> South Sudan | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> Panama | <input type="checkbox"/> Spain | |

7. State of residence of recipient: (for residents of Brazil)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acre | <input type="checkbox"/> Maranhão | <input type="checkbox"/> Rio de Janeiro |
| <input type="checkbox"/> Alagoas | <input type="checkbox"/> Mato Grosso | <input type="checkbox"/> Rio Grande do Norte |
| <input type="checkbox"/> Amapá | <input type="checkbox"/> Mato Grosso do Sul | <input type="checkbox"/> Rio Grande do Sul |
| <input type="checkbox"/> Amazonas | <input type="checkbox"/> Minas Gerais | <input type="checkbox"/> Rondônia |
| <input type="checkbox"/> Bahia | <input type="checkbox"/> Pará | <input type="checkbox"/> Roraima |
| <input type="checkbox"/> Ceará | <input type="checkbox"/> Paraná | <input type="checkbox"/> Santa Catarina |
| <input type="checkbox"/> Distrito Federal | <input type="checkbox"/> Paraíba | <input type="checkbox"/> São Paulo |
| <input type="checkbox"/> Espírito Santo | <input type="checkbox"/> Pernambuco | <input type="checkbox"/> Sergipe |
| <input type="checkbox"/> Goiás | <input type="checkbox"/> Piauí | <input type="checkbox"/> Tocantins |

8. Province or territory of residence of recipient: (for residents of Canada)

- | | | |
|--|---|--|
| Provinces: | | Territories: |
| <input type="checkbox"/> Alberta | <input type="checkbox"/> Nova Scotia | <input type="checkbox"/> Northwest Territories |
| <input type="checkbox"/> British Columbia | <input type="checkbox"/> Ontario | <input type="checkbox"/> Nunavut |
| <input type="checkbox"/> Quebec | <input type="checkbox"/> Prince Edward Island | <input type="checkbox"/> Yukon |
| <input type="checkbox"/> Manitoba | <input type="checkbox"/> Quebec | |
| <input type="checkbox"/> New Brunswick | <input type="checkbox"/> Saskatchewan | |
| <input type="checkbox"/> Newfoundland and Labrador | | |

9. State of residence of recipient: (for residents of USA)

- | | | |
|---|---|---|
| <input type="checkbox"/> Alabama | <input type="checkbox"/> Kentucky | <input type="checkbox"/> North Dakota |
| <input type="checkbox"/> Alaska | <input type="checkbox"/> Louisiana | <input type="checkbox"/> Ohio |
| <input type="checkbox"/> Arizona | <input type="checkbox"/> Maine | <input type="checkbox"/> Oklahoma |
| <input type="checkbox"/> Arkansas | <input type="checkbox"/> Maryland | <input type="checkbox"/> Oregon |
| <input type="checkbox"/> California | <input type="checkbox"/> Massachusetts | <input type="checkbox"/> Pennsylvania |
| <input type="checkbox"/> Colorado | <input type="checkbox"/> Michigan | <input type="checkbox"/> Rhode Island |
| <input type="checkbox"/> Connecticut | <input type="checkbox"/> Minnesota | <input type="checkbox"/> South Carolina |
| <input type="checkbox"/> Delaware | <input type="checkbox"/> Mississippi | <input type="checkbox"/> South Dakota |
| <input type="checkbox"/> District of Columbia | <input type="checkbox"/> Missouri | <input type="checkbox"/> Tennessee |
| <input type="checkbox"/> Florida | <input type="checkbox"/> Montana | <input type="checkbox"/> Texas |
| <input type="checkbox"/> Georgia | <input type="checkbox"/> Nebraska | <input type="checkbox"/> Utah |
| <input type="checkbox"/> Hawaii | <input type="checkbox"/> Nevada | <input type="checkbox"/> Vermont |
| <input type="checkbox"/> Idaho | <input type="checkbox"/> New Hampshire | <input type="checkbox"/> Virginia |
| <input type="checkbox"/> Illinois | <input type="checkbox"/> New Jersey | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Indiana | <input type="checkbox"/> New Mexico | <input type="checkbox"/> West Virginia |
| <input type="checkbox"/> Iowa | <input type="checkbox"/> New York | <input type="checkbox"/> Wisconsin |
| <input type="checkbox"/> Kansas | <input type="checkbox"/> North Carolina | <input type="checkbox"/> Wyoming |

10. NMDP Recipient ID (RID): _____

11. Zip or postal code for place of recipient's residence (USA recipients only): _____ - _____ (last 4 digits optional)

12. Specify blood type: (recipient) **(For allogeneic HCTs only)** A B AB O

13. Specify Rh factor: (recipient) **(For allogeneic HCTs only)** Positive Negative

14. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form for submitting research data to the NMDP / CIBMTR?

- Yes (recipient consented) →
- No (recipient declined)
- Not approached

15. Did the recipient give permission to be directly contacted by CIBMTR for future research?

- Yes (recipient provided permission) →
- No (recipient declined)

16. Date form was signed:

__ __ / __ __ / __ __
 YYYY MM DD

17. Has the recipient signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR?

- Yes (recipient consented) →
- No (recipient declined)
- Not approached
- Not applicable (center not participating)

18. Date form was signed: __ __ / __ __ / __ __
 YYYY MM DD

19. Did the recipient submit a research sample to the NMDP/CIBMTR repository? **(Related donors only)**

- Yes →
- No

20. Research sample recipient ID:

21. Is the recipient participating in a clinical trial? (clinical trial sponsors that uses CIBMTR forms to capture outcomes data)

- Yes →
- No

22. Study Sponsor:
- BMT-CTN - **Go to question 24**
 - RCI-BMT - **Go to question 24**
 - PIDTC - **Go to question 24**
 - USIDNET - **Go to question 25**
 - COG - **Go to question 25**
 - Other sponsor - **Go to question 23**

23. Specify other sponsor: _____
 - **Go to question 25**

24. Study ID Number: _____

25. Subject ID: _____

Copy questions 22-25 to report participation in more than one study.

Hematopoietic Cellular Transplant (HCT) and Cellular Therapy

26. Is a subsequent HCT planned as part of the overall treatment protocol (not as a reaction to post-HCT disease assessment)? **(For autologous HCTs only)**

- Yes →
- No

27. Specify subsequent HCT planned: Autologous Allogeneic

28. Has the recipient ever had a prior HCT?

- Yes →
- No

29. Specify the number of prior HCTs: _____

30. Were all prior HCTs reported to the CIBMTR? Yes No Unknown

Copy and complete questions 31-39 to report all prior HCTs that have not yet been reported to the CIBMTR:

31. Date of the prior HCT: ____ / ____ / ____ Date estimated
YYYY MM DD

32. Was the prior HCT performed at a different institution?

- Yes →
- No

Specify the institution that performed the last HCT:

33. Name: _____
 City: _____
 State: _____
 Country: _____

34. What was the HPC source for the prior HCT?

- Autologous
- Allogeneic, unrelated donor
- Allogeneic, related donor

35. Reason for current HCT:

- Graft failure / insufficient hematopoietic recovery - **Go to question 36**
- Persistent primary disease - **Go to question 40**
- Recurrent primary disease - **Go to question 37**
- Planned subsequent HCT, per protocol - **Go to question 40**
- New malignancy (including PTLD and EBV lymphoma) - **Go to question 38**
- Insufficient chimerism - **Go to question 40**
- Other - **Go to question 39**

36. Date of graft failure / rejection: ____ / ____ / ____
YYYY MM DD
- Go to question 40

37. Date of relapse: : ____ / ____ / ____
YYYY MM DD
- Go to question 40

38. Date of secondary malignancy: ____ / ____ / ____
YYYY MM DD
- Go to question 40

39. Specify other reason: _____

40. Has the recipient ever had a prior cellular therapy? (do not include DLIs)

- Yes →
- No
- Unknown

41. Were all prior cellular therapies reported to the CIBMTR?

- Yes
- No →
- Unknown

Copy and complete questions 43-46 to report all prior cellular therapies that have not yet been reported to the CIBMTR:

42. Date of the prior cellular therapy: __ __ __ __ / __ __ / __ __
YYYY MM DD

43. Was the cellular therapy performed at a different institution?

- Yes →
- No

44. Name: _____
 City: _____
 State: _____
 Country: _____

45. Specify the source(s) for the prior cellular therapy: (check all that apply)

- Autologous
- Allogeneic, unrelated donor
- Allogeneic, related donor

Donor Information

46. Multiple donors?

- Yes →
- No

47. Specify number of donors: _____

To report more than one donor, copy questions 48-83 and complete for each donor.

48. Specify donor:

- Autologous
- Allogeneic, related
- Allogeneic, unrelated

49. Specify product type: (check all that apply)

- Bone marrow
- PBSC
- Single cord blood unit
- Other product →

50. Specify other product type: _____

51. Is the product genetically modified? **If autologous, go to question 58. If allogeneic related, go to question 52. If allogeneic unrelated, go to question 56.**

- Yes
- No

52. Specify the related donor type:

- Syngeneic (monozygotic twin) - **Go to question 55**
- HLA-identical sibling (may include non-monozygotic twin) - **Go to question 55**
- HLA-matched other relative (does NOT include a haplo-identical donor) - **Go to question 53**
- HLA-mismatched relative - **Go to question 53**

53. Specify related relationship

- Recipient's mother
- Recipient's father
- Recipient's child
- Maternal aunt
- Maternal uncle
- Maternal cousin
- Paternal aunt
- Paternal uncle
- Paternal cousin
- Grandparent
- Grandchild
- Other biological relative →

54. Specify other biological relative:

55. Degree of mismatch:

- HLA-mismatched 1 allele - **Go to question 57**
- HLA-mismatched ≥2 alleles (does include haplo-identical donor)
- **Go to question 57**

56. Specify unrelated donor type HLA matched unrelated HLA mismatched unrelated

57. Did NMDP/Be the Match facilitate the procurement, collections, or transportation of the product?
 Yes No

58. Was this donor used for any prior HCTs? (for this recipient) **If auto, go to question 80** Yes No

59. NMDP unrelated cord blood unit ID: _____ - **Go to question 63**

60. NMDP unrelated donor ID: _____ - **Go to question 63**

61. Non-NMDP unrelated donor ID: (not applicable for related donors)
_____ - **Go to question 63**

62. Non-NMDP cord blood unit ID: (include related and autologous CBUs)
_____ - **Go to question 63**

63. Global Registration Identifier for Donors (GRID):
_____ (optional)

NMDP cord blood unit, go to question 75
NMDP donor, go to question 75
Non-NMDP unrelated donor, go to question 66
Non-NMDP cord blood unit, go to question 64

64. Is the CBU ID also the ISBT DIN number?
 Yes
 No →
 Unknown

65. Specify the ISBT DIN number: _____

66. Registry or UCB Bank ID: _____ - **If 'Other registry' go to 67, otherwise go to question 68**

67. Specify other Registry or UCB Bank: _____

68. Date of birth: (donor / infant)

Known →

69. Date of birth: (donor / infant) __ __ / __ __ / __ __ - **Go to question 72**
 YYYY MM DD

Unknown →

70. Age: (donor / infant)

Known →

Unknown

71. Age: (donor / infant) ____

Months (use only if less than 1 year old)

Years

72. Sex: (donor / infant) Male Female

73. Specify blood type: (donor) **(non-NMDP allogeneic donors only)** A B AB O

74. Specify Rh factor: (donor) **(non-NMDP allogeneic donors only)** Positive Negative

75. Donor CMV-antibodies (IgG or Total) (Allogeneic HCTs only)

Reactive Non-reactive Indeterminant Not done Not applicable (cord blood unit)

76. Has the donor signed an IRB / ethics committee (or similar body) approved consent form to donate research blood samples to the NMDP / CIBMTR? **(Related donors only)**

- Yes (donor consented)
- No (donor declined) →
- Not approached
- Not applicable (center not participating)

77. Date form was signed: __ __ / __ __ / __ __
 YYYY MM DD

78. Did the donor submit a research sample to the NMDP/CIBMTR repository? **(Related donors only)**

Yes →

No

79. Research sample donor ID:

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.

80. Specify number of products infused from this donor: _____

81. Specify the number of these products intended to achieve hematopoietic engraftment: _____

Questions 82-83 are for autologous HCT recipients only. If other than autologous skip to question 84.

82. What agents were used to mobilize the autologous recipient for this HCT? (check all that apply)

- G-CSF (filgrastim, Neupogen)
 Pegylated G-CSF (pegfilgrastim, Neulasta)
 Plerixafor (Mozobil)
 Combined with chemotherapy
 Anti-CD20 (rituximab, Rituxan)
 Other agent

83. Specify other agent: _____

To report more than one donor, copy questions 48-83 and complete for each donor.

Clinical Status of Recipient Prior to the Preparative Regimen (Conditioning)

84. What scale was used to determine the recipient's functional status?

- Karnofsky (recipient age \geq 16 years)

Performance score prior to the preparative regimen:

85. Karnofsky Scale (recipient age \geq 16 years):

- 100 Normal; no complaints; no evidence of disease
 90 Able to carry on normal activity
 80 Normal activity with effort
 70 Cares for self; unable to carry on normal activity or to do active work
 60 Requires occasional assistance but is able to care for most needs
 50 Requires considerable assistance and frequent medical care
 40 Disabled; requires special care and assistance
 30 Severely disabled; hospitalization indicated, although death not imminent
 20 Very sick; hospitalization necessary
 10 Moribund; fatal process progressing rapidly.

- Lansky (recipient age \geq 1 year and $<$ 16 years)

86. Lansky Scale (recipient age \geq 1 year and $<$ 16 years):

- 100 Fully active
 90 Minor restriction in physically strenuous play
 80 Restricted in strenuous play, tires more easily, otherwise active
 70 Both greater restrictions of, and less time spent in, active play
 60 Ambulatory up to 50% of time, limited active play with assistance/supervision
 50 Considerable assistance required for any active play; fully able to engage in quiet play
 40 Able to initiate quiet activities
 30 Needs considerable assistance for quiet activity
 20 Limited to very passive activity initiated by others (e.g., TV)
 10 Completely disabled, not even passive play

87. Recipient CMV-antibodies (IgG or Total):

- Reactive Non-reactive Indeterminant Not done

Co-morbid Conditions	
88.	Is there a history of mechanical ventilation? <input type="checkbox"/> Yes <input type="checkbox"/> No
89.	Is there a history of invasive fungal infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
90.	Glomerular filtration rate (GFR) before start of preparative regimen <input type="checkbox"/> Known → 91. Glomerular filtration rate (GFR): ___ ___ mL/min/1.73² <input type="checkbox"/> Unknown
92.	Does the recipient have known complex congenital heart disease (corrected or uncorrected)? (excluding simple ASD, VSD, or PDA repair) (pediatric only) <input type="checkbox"/> Yes <input type="checkbox"/> No
93.	Were there any co-existing diseases or organ impairment present according to the HCT comorbidity index (HCT-CI)? Source: Sorror, M. L. (2013). How I assess comorbidities before hematopoietic cell transplantation. Blood, 121(15), 2854-2863. <input type="checkbox"/> Yes → <input type="checkbox"/> No
94.	Specify co-existing diseases or organ impairment (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Arrhythmia – Any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment <input type="checkbox"/> Cardiac – Any history of coronary artery disease (one or more vessel-coronary artery stenosis requiring medical treatment, stent, or bypass graft), congestive heart failure, myocardial infarction, OR ejection fraction ≤ 50% on the most recent test <input type="checkbox"/> Cerebrovascular disease – Any history of transient ischemic attack, subarachnoid hemorrhage or cerebral thrombosis, embolism, or hemorrhage <input type="checkbox"/> Diabetes – Requiring treatment with insulin or oral hypoglycemic drugs in the last 4 weeks but not diet alone <input type="checkbox"/> Heart valve disease – At least a moderate to severe degree of valve stenosis or insufficiency as determined by Echo; prosthetic mitral or aortic valve; or symptomatic mitral valve prolapse <input type="checkbox"/> Hepatic, mild – bilirubin > upper limit of normal to 1.5 × upper limit of normal, or AST/ALT > upper limit of normal to 2.5 × upper limit of normal at the time of transplant OR any history of hepatitis B or hepatitis C infection <input type="checkbox"/> Hepatic, moderate/severe – Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal <input type="checkbox"/> Infection – Includes a documented infection, fever of unknown origin, or pulmonary nodules suspicious for fungal pneumonia or a positive PPD test requiring prophylaxis against tuberculosis. Patients must have started antimicrobial treatment before Day 0 with continuation of antimicrobial treatment after day 0 <input type="checkbox"/> Inflammatory bowel disease – Any history of Crohn’s disease or ulcerative colitis requiring treatment <input type="checkbox"/> Obesity – Patients older than 18 years with a body mass index (BMI) > 35 kg/m² prior to the start of conditioning or a BMI of the 95th percentile or higher for patients aged 18 years or younger <input type="checkbox"/> Peptic ulcer – Any history of peptic (gastric or duodenal) ulcer confirmed by endoscopy or radiologic diagnosis requiring treatment <input type="checkbox"/> Psychiatric disturbance – Presence of any mood (e.g., depression), anxiety, or other psychiatric disorder (e.g. bipolar disorder or schizophrenia) requiring continuous treatment in the last 4 weeks <input type="checkbox"/> Pulmonary, moderate – Corrected diffusion capacity of carbon monoxide and/or FEV1 of 66-80% or dyspnea on slight activity attributed to pulmonary disease at transplant <input type="checkbox"/> Pulmonary, severe – Corrected diffusion capacity of carbon monoxide and/or FEV1 of ≤ 65% or dyspnea at rest attributed to pulmonary disease or the need for intermittent or continuous oxygen during the 4 weeks prior to transplant <input type="checkbox"/> Renal, moderate / severe – Serum creatinine > 2 mg/dL or > 177 μmol/L; on dialysis at during the 4 weeks prior to transplant; OR prior renal transplantation - Go to question 95 <input type="checkbox"/> Rheumatologic – Any history of a rheumatologic disease (e.g., systemic lupus erythematosus, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica, etc.) requiring treatment. (Do NOT include degenerative joint disease, osteoarthritis) <input type="checkbox"/> Prior malignancy, specify – Treated at any time point in the patient’s past history, other than the primary disease for which this HCT is being performed - go to question 97

106. Platelets: (with 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

Known →

Unknown

107. _____ x 10⁹/L (x 10³/mm³) x 10⁶/L

108. Were platelets transfused ≤ 7 days before date of test?

Yes No Unknown

109. Did the recipient have a prior solid organ transplant?

Known →

Unknown

110. Specify organ:

Bowel

Heart

Kidney(s)

Liver

Lung(s)

Pancreas

Other organ →

111. Specify other organ: _____

112. Year of prior solid organ transplant: _____

Copy and complete questions 110-112 for each prior solid organ transplant

Pre-HCT Preparative Regimen (Conditioning)

113. Height at initiation of pre-HCT preparative regimen: _____ inches centimeters

114. Actual weight at initiation of pre-HCT preparative regimen: _____ • _____ pounds kilograms

115. Was a pre-HCT preparative regimen prescribed?

Yes →

No

116. Classify the recipient's prescribed preparative regimen: **(Allogeneic HCTs only)**

Myeloablative Non-myeloablative (NST) Reduced intensity (RIC)

117. Was irradiation planned as part of the pre-HCT preparative regimen?

Yes →

No

118. What was the prescribed radiation field?

Total body

Total body by intensity-modulated radiation therapy (IMRT)

Total lymphoid or nodal regions

Thoracoabdominal region

119. Total prescribed dose: (dose per fraction x total number of fractions) _____ • _____ Gy cGy

120. Date started: ____ / ____ / ____

YYYY MM DD

121. Was the radiation fractionated?

Yes →

No

122. Total number of fractions: _____

Indicate the total prescribed cumulative dose for the preparative regimen:

123. Drug: (choose from list)

- Bendamustine
- Busulfan
- Carboplatin
- Carmustine (BCNU)
- CCNU (Lomustine)
- Clofarabine (Clolar)
- Cyclophosphamide (Cytosan)
- Cytarabine (Ara-C)
- Etoposide (VP-16, VePesid)
- Fludarabine
- Gemcitabine
- Ibritumomab tiuxetan (Zevalin)
- Ifosfamide
- Melphalan (L-Pam)
- Methylprednisolone (Solu-Medrol)
- Pentostatin
- Propylene glycol-free melphalan (Evomela)
- Rituximab (Rituxan)
- Thiotepa
- Tositumomab (Bexxar)
- Treosulfan
- Other drug →

124. Specify other drug: _____

125. Total prescribed dose: _____ • mg/m² mg/kg AUC

126. Date started: ____ / ____ / ____
 YYYY MM DD

127. Specify administration: (busulfan only) Oral IV Both

Copy and complete question 123-126 to report each drug given for the preparative regimen

Additional drugs given in the peri-transplant period

128. ALG, ALS, ATG, ATS

- Yes →
 No

129. Total prescribed dose: _____ mg/kg

130. Specify source:

- ATGAM (horse)
 ATG – Fresenius (rabbit)
 Thymoglobulin (rabbit)
 Other →

131. Specify other source: _____

132. Alemtuzumab (Campath)

- Yes →
 No

133. Total prescribed dose: _____ • ___ mg/m² mg/kg mg

134. Defibrotide

Yes No

135. KGF

Yes No

136. Ursodiol

Yes No

GVHD Prophylaxis

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 141

137. Was GVHD prophylaxis planned?

- Yes →
 No

138. Specify drugs / intervention: (check all that apply)

- Abatacept
 Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
 Bortezomib
 CD34 enriched (CD34+ selection)
 Corticosteroids (systemic)
 Cyclosporine (CSA, Neoral, Sandimmune)
 Cyclophosphamide (Cytoxan)
 Extra-corporeal photopheresis (ECP)
 Ex-vivo T-cell depletion
 Filgotinib
 Maraviroc
 Methotrexate (MTX) (Amethopterin)
 Mycophenolate mofetil (MMF) (CellCept)
 Ruxolotinib
 Sirolimus (Rapamycin, Rapamune)
 Tocilizumab
 Tacrolimus (FK 506)
 Blinded randomized trial
 Other agent →

139. Specify other agent: _____
 (do not report ATG, campath)

Post-HCT Disease Therapy Planned as of Day 0

140. Is additional post-HCT therapy planned?

- Yes →
- No

Questions 141-142 are optional for non-U.S. centers

141. Specify post-HCT therapy planned: (check all that apply)

- Azacytidine (Vidaza)
- Blinatumomab
- Bortezomib (Velcade)
- Bosutinib
- Brentuximab
- Carfilzomib
- Cellular therapy (e.g. DCI, DLI)
- Crenolanib
- Daratumumab
- Dasatinib
- Decitabine
- Elotuzumab
- Enasidenib
- Gilteritinib
- Ibrutinib
- Imatinib mesylate
- Intrathecal therapy (chemotherapy)
- Ivosidenib
- Ixazomib
- Lenalidomide (Revlimid)
- Lestaurtinib
- Local radiotherapy
- Midostaurin
- Nilotinib
- Obinutuzumab
- Pacritinib
- Ponatinib
- Quizartinib
- Rituximab (Rituxan, MabThera)
- Sorafenib
- Sunitinib
- Thalidomide (Thalomid)
- Other therapy →
- Unknown

142. Specify other therapy: _____

First Name: _____

Last Name: _____

E-mail address: _____

Date: __ __ / __ __ / __ __
YYYY MM DD