CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Hematopoietic Cellular Transplant (HCT) Infusion

Registry Use Only
Sequence Number:

Date Received:

OMB No: 0915-0310
Expiration Date: 1/31/2020

CIBMTR Center Number: ___ ___ ___ ___ ___

CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Event Date: __ __ __ __ / __ __ / __ __
YYY MM DD

HCT type (check only one) ☐ Autologous ☐ Allogeneic, unrelated ☐ Allogeneic, related

Product type (check only one) ☐ Bone marrow
☐ PBSC
☐ Single cord blood unit
☐ Other product. Specify:_____

NMDP Product: ☐ Yes ☐ No

Product Identifiers:

NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

NMDP donor ID: __ __ __ __ - __ __ __ __ - __

Non-NMDP unrelated donor ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Non-NMDP cord blood unit ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

GRID (optional): __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

ISBT DIN: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Registry or UCB Bank ID: __ __ __ __

Donor DOB: __ __ __ __ / __ __ / __ __
YYYY MM DD

Donor Age: __ __ ☐ Months (use only if less than 1 year old) ☐ Years

Donor Sex: ☐ Male ☐ Female

If more than one type of HCT product is infused, each product type must be analyzed and reported separately.

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 growth and mobilizing factors, prior to any stem cell harvest, to enhance the product collection for this HCT? **Allogeneic donors only**

☐ Yes →
☐ No

2. Specify growth and mobilizing factor(s) (Check all that apply)
   - ☐ G-CSF (filgrastim, Neupogen)
   - ☐ Pegylated G-CSF (pegfilgrastim, Neulasta)
   - ☐ Plerixafor (Mozobil)
   - ☐ Other growth or mobilizing factor(s) →

3. Specify other growth or mobilizing factor(s):
   _____

Product Collection

4. Date of first collection for this mobilization: __ __ __ __ / __ __ / __ __
   YYYY MM DD

5. Were anticoagulants or other agents added to the product between collection and infusion?

☐ Yes →
☐ No

6. Specify anticoagulant(s): (check all that apply)
   - ☐ Acid citrate dextrose (ACD, ACD-A)
   - ☐ Citrate phosphate dextrose (CPD, CPD-A)
   - ☐ Ethylenediaminetetraacetic acid (EDTA)
   - ☐ Heparin
   - ☐ Other →

7. Specify other anticoagulant:
   _____

Product Transport and Receipt

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

☐ Yes →
☐ No

9. Date of receipt of product at your facility: __ __ __ __ / __ __ / __ __
   YYYY MM DD

10. Time of receipt of product (24-hour clock):

___ ___ : ___ ___ ☐ standard time ☐ daylight savings time
Hour Minute

11. Specify the shipping environment of the product(s)

- ☐ Room temperature
- ☐ Cooled (refrigerator temperature, not frozen)
- ☐ Frozen (cryopreserved)
- ☐ Other shipping environment →

12. Specify other shipping environment:

_____

– If product is cord blood, go to question 13; all other products go to question 22

13. Was there any indication that the environment within the shipper was outside the expected temperature range for this product at any time during shipment?

☐ Yes ☐ No

14 Were the secondary containers (e.g., insulated shipping containers and unit cassette) intact when they arrived at your center?

☐ Yes ☐ No

15. Was the cord blood unit stored at your center prior to thawing? **(Cord blood units only)**

- ☐ Yes →
- ☐ No

16. Specify the storage method used for the cord blood unit

☐ Electric freezer ☐ Liquid nitrogen ☐ Vapor phase

17. Temperature during storage

- ☐ < -150° C
- ☐ ≥ -150° C to < -135° C
- ☐ ≥ -135° C to < -80° C
- ☐ ≥ -80° C

18. Date storage started: __ __ __ __ / __ __ / __ __
YYYY MM DD

Report the total number of cells (not cells per kilogram) prior to cryopreservation: (Information provided for the unit by the cord blood bank).

19. Total nucleated cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___ (Includes nucleated red and nucleated white cells) **(Cord blood units only)**

20. CD34+ cells **(cord blood units only)**

- ☐ Done →
- ☐ Not done

21. Total number of CD34+ cells:

___ ___ ___ ___ • ___ ___ x 10 ___ ___

Product Processing / Manipulation

22. Was the product thawed from a cryopreserved state prior to infusion?
- ☐ Yes →
- ☐ No

23. Was the entire product thawed?
- ☐ Yes
- ☐ No →

24. Specify the percent of the product that was thawed? **(Cord blood units only)**
- ☐ 80%
- ☐ 20%
- ☐ Other percent →

25. Specify other percent: __ __ %

26. Date thawing process initiated: __ __ __ __ / __ __ / __ __
YYYY MM DD

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

28. Time of thaw completion (24-hour clock): ___ ___ : ___ ___ ☐ standard time ☐ daylight savings time
Hour Minute

29. What method was used to thaw the product?
- ☐ Waterbath
- ☐ Electric warmer
- ☐ Other method →

30. Specify other method:_____

31. Did any incidents, or product complaints occur while preparing or thawing the product? ☐ yes ☐ no

32. Was the product **processed** prior to infusion?
- ☐ Yes →
- ☐ No

33. Specify processing: (check all that apply)
- ☐ Buffy coat enriched (buffy coat preparation)
- ☐ Diluted
- ☐ Plasma reduced
- ☐ RBC reduced
- ☐ Washed

34. Was the product **manipulated** prior to infusion?
- ☐ Yes →
- ☐ No

35. Specify manipulations performed: (check all that apply)
- ☐ Antibodies ***- Go to question 36***
- ☐ Ex-vivo expansion ***- Go to question 36***
- ☐ Genetic manipulation (gene transfer / transduction) ***- Go to question 36***
- ☐ CD34 enriched (CD34+ selection) ***- Go to question 36***
- ☐ Ex-vivo T-cell depletion ***- Go to question 38***
- ☐ Other manipulation ***- Go to question 40***

36. Specify antibodies used: (check all that apply)
- ☐ Anti CD3
- ☐ Anti CD4
- ☐ Anti CD8
- ☐ Anti CD19
- ☐ Anti CD34
- ☐ Anti CD45RA
- ☐ α/β Antibody
- ☐ Anti CD52
- ☐ Other antibody → 37. Specify other antibody: _____

38. Specify T-cell depletion method:
- ☐ Antibody affinity column
- ☐ Immunomagnetic beads
- ☐ Other method → 39. Specify other method: _____

40. Specify other cell manipulation: _____

Product Analysis (All Products)

41. Specify the timepoint in the product preparation phase that the product was analyzed:
☐ Product arrival (cord blood only) ☐ At infusion (final quantity infused)

42. Date of product analysis: __ __ __ __ / __ __ / __ __
YYYY MM DD

43. Total volume of product plus additives : ___ ___ ___ ___ ___ • ___mL

In this section, report the total number of cells (not cells per kilogram) and do not correct for viability.

44. Total nucleated cells (TNC) (Includes nucleated red and nucleated white cells)
- ☐ Done →
  - 45. Total nucleated cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___
  - 46. Viability of cells
    - ☐ Done →
      - 47. Viability of cells: ___ ___ ___ %
      - 48. Method of testing cell viability:
        - ☐ Flow cytometry based
        - ☐ Trypan blue
        - ☐ Other method → 49. Specify other method: _____
    - ☐ Not done
    - ☐ Unknown
- ☐ Not done

50. Nucleated white blood cells
- ☐ Done →
- ☐ Not done

51. Total number of nucleated white blood cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

52. Mononuclear cells
- ☐ Done →
- ☐ Not done

53. Total number of mononuclear cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

54. Nucleated red blood cells
- ☐ Done →
- ☐ Not done

55. Total number of nucleated red blood cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

56. CD34+ cells
- ☐ Done →
- ☐ Not done

57. Total number of CD34+ cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

58. Viability of cells
- ☐ Done →
- ☐ Not done
- ☐ Unknown

59. Viability of cells: ___ ___ ___ %

60. Method of testing cell viability:
- ☐ Flow cytometry based
- ☐ Trypan blue
- ☐ Other method →

61. Specify other method: _____

62. CD3+ cells
- ☐ Done →
- ☐ Not done

63. Total number of CD3+ cells: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

64. Viability of cells
- ☐ Done →
- ☐ Not done
- ☐ Unknown

65. Viability of cells: ___ ___ ___ %

66. Method of testing cell viability:
- ☐ Flow cytometry based
- ☐ Trypan blue
- ☐ Other method →

67. Specify other method: _____

68. CD3+CD4+ cells
- ☐ Done →
- ☐ Not done

69. Total number of CD3+CD4+: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

70. Viability of cells
- ☐ Done →
- ☐ Not done
- ☐ Unknown

71. Viability of cells: ___ ___ ___ %

72. Method of testing cell viability:
- ☐ Flow cytometry based
- ☐ Trypan blue
- ☐ Other method →

73. Specify other method: _____

74. CD3+CD8+ cells
- ☐ Done →
- ☐ Not done

75. Total number of CD3+CD8+: ___ ___ ___ ___ • ___ ___ x 10 ___ ___

76. Viability of cells
- ☐ Done →
- ☐ Not done
- ☐ Unknown

77. Viability of cells: ___ ___ ___ %

78. Method of testing cell viability:
- ☐ Flow cytometry based
- ☐ Trypan blue
- ☐ Other method →

79. Specify other method: _____

80. Were the colony-forming units (CFU) assessed after thawing? **(cord blood units only)**
- ☐ Yes →
- ☐ No

81. Was there growth? ☐ Yes ☐ No

82. Total CFU-GM
- ☐ Done →
- ☐ Not done

83. Total CFU-GM: ___ ___ ___ ___ • ___ x 10 ___ ___

84. Total CFU-GEMM
- ☐ Done →
- ☐ Not done

85. Total CFU-GEMM: ___ ___ ___ ___ • ___ x 10 ___ ___

86. Total BFU-E
- ☐ Done →
- ☐ Not done

87. Total BFU-E: ___ ___ ___ ___ • ___ x 10 ___ ___

88. Were any positive cultures (for bacterial or fungal infections) obtained from the product at the transplant center? (complete for all cell products)

- ☐ Yes →
- ☐ No
- ☐ Pending
- ☐ Unknown

Specify organism code(s):

89. ___ ___ ___ 90. ___ ___ ___ 91. ___ ___ ___ 92. ___ ___ ___

93. Specify organism: _____

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

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 nondiptheria 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

Copy questions 41-93 to report multiple instances of Product Analysis

Product Infusion

94. Date of this product infusion: __ __ __ __ / __ __ / __ __
YYYY MM DD

95. Was the entire volume of received product infused?
- ☐ Yes →
- ☐ No

96. Specify what happened to the reserved portion:
- ☐ Discarded
- ☐ Cryopreserved for future use
- ☐ Other fate →

97. Specify other fate:_____

98. Time product infusion initiated (24-hour clock): ___ ___ : ___ ___ ☐ standard time ☐ daylight savings time
Hour Minute

99. Date infusion stopped: __ __ __ __ / __ __ / __ __
YYYY MM DD

100. Time product infusion completed (24-hour clock): ___ ___ : ___ ___ ☐ standard time ☐ daylight savings time
Hour Minute

101. Specify the route of product infusion:

- ☐ Intravenous
- ☐ Intramedullary (Intraosseous)
- ☐ Other route of infusion →

102. Specify other route of infusion: _____

The following questions are applicable to cord blood units only. Non-NMDP allogeneic products continue with question 144. Autologous and NMDP products continue with the signature lines.

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

- ☐ Yes →
- ☐ No

Specify the following adverse event(s):

104. Brachycardia
- ☐ Yes →
- ☐ No

105. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

106. Chest tightness / pain
- ☐ Yes →
- ☐ No

107. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

108. Chills at time of infusion
- ☐ Yes →
- ☐ No

109. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

110. Fever ≤ 103° F within 24 hours of infusion
- ☐ Yes →
- ☐ No

111. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

112. Fever > 103° F within 24 hours of infusion
- ☐ Yes →
- ☐ No

113. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

114. Gross hemoglobinuria
- ☐ Yes →
- ☐ No

115. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

116. Headache
☐ Yes → 1174. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

118. Hives
☐ Yes → 119. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

120. Hypertension
☐ Yes → 121. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

122. Hypotension
☐ Yes → 123. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

124. Hypoxia requiring oxygen (O_2) support
☐ Yes → 125. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

126. Nausea
☐ Yes → 127. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

128. Rigors, mild
☐ Yes → 129. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

130. Rigors, severe
☐ Yes → 131. In the Medical Director's judgment, was the adverse event a direct result of the infusion? ☐ Yes ☐ No
☐ No

132. Shortness of breath (SOB)

☐ Yes → 133. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

☐ No

134. Tachycardia

☐ Yes → 135. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

☐ No

136. Vomiting

☐ Yes → 137. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

☐ No

138. Other expected AE

☐ Yes → 139. Specify other expected AE: _____

140. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

☐ No

141. Other unexpected AE

☐ Yes → 142. Specify other unexpected AE: _____

143. In the Medical Director's judgment, was the adverse event a direct result of the infusion?
☐ Yes ☐ No

☐ No

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Donor / Infant Demographic Information

This Donor Demographic Information section (questions 144-170) is to be completed for all non-NMDP allogeneic donors. If the stem cell product was from an NMDP donor or an autologous donor, continue with the signature lines.

144. Was the donor ever pregnant?
- ☐ Yes →
- ☐ No
- ☐ Unknown
- ☐ Not applicable (male donor or cord blood unit)

145. Number of pregnancies
- ☐ Known →
- ☐ Unknown

146. Specify number of pregnancies: ___ ___

147. Did this donor have a central line placed? ☐ Yes ☐ No ☐ Unknown

148. Ethnicity (donor) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not applicable (not a resident of the USA) ☐ Unknown

149. Race (donor) (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 151

150. Race detail (donor) (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 (both parents born in Africa)
- ☐ 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

151. Was the donor a carrier for potentially transplantable genetic diseases?
- ☐ Yes →
- ☐ No

152. Specify potentially transplantable genetic disease:
- ☐ Sickle cell anemia
- ☐ Thalassemia
- ☐ Other hemoglobinopathy
- ☐ Other disease →

153. Specify other disease: _____

154. Was the donor / product tested for other transferable genetic or clonal abnormalities?
- ☐ Yes ***- Go to question 155***
- ☐ No ***- If this is a related donor, go to question 160; all other donor types go to signature line***
- ☐ Unknown ***- If this is a related donor, go to question 160; all other donor types go to signature line***

155. Clonal hematopoiesis of indeterminate potential (CHIP):
- ☐ Yes →
- ☐ No

156. What was the method of testing used?_____

157. Monoclonal B-cell lymphocytosis ☐ Yes ☐ No

158. Other transferable genetic or clonal abnormality
- ☐ Yes →
- ☐ No

159. Specify other transferable genetic or clonal abnormality:

_____

The following questions (160–167) apply only to allogeneic related donors. If the stem cell product was from an autologous donor, Non-NMDP unrelated donor, NMDP donor, or was a cord blood unit, then continue with the signature lines.

160. Was the donor hospitalized (inpatient) during or after the collection? ☐ yes ☐ no

161. Did the donor experience any life-threatening complications during or after the collection?
- ☐ Yes →
- ☐ No

162. Specify:_____

163. Did the allogeneic donor give one or more autologous transfusion units?

☐ Yes → 164. Date of collection: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)

165. Number of units: __ __

☐ No

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

☐ Autologous transfusions → 167. Specify number of autologous units: ___ ___

☐ Allogenic transfusions → 168. Specify number of allogenic units: ___ ___

☐ No

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

☐ Yes → 170. Specify cause of death: _____

☐ No ***- Go to signature line***

First Name (person completing form): _____

Last Name:_____

E-mail address: _____

Date: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Confirmation of HLA Typing

Registry Use Only
Sequence Number:

Date Received:

OMB No: 0915-0310
Expiration Date: 1/31/2020

CIBMTR Center Number: ___ ___ ___ ___ ___

CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

Product Identifiers:

NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Non-NMDP unrelated donor ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Non-NMDP cord blood unit ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

GRID (optional): __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

ISBT DIN: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Registry or UCB Bank ID: __ __ __ __

Donor DOB: __ __ __ __ / __ __ / __ __
YYYY MM DD

Donor Age: __ __ ☐ Months (use only if less than 1 year old) ☐ Years

Donor Sex: ☐ Male ☐ Female

Donor/Cord Blood Unit Identification

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. Parental typing (maternal and paternal) should be submitted for all mismatched related donor transplants (CRF track only), if available. Cord blood maternal typing should be submitted for all unrelated cord blood transplants (CRF track only), if available.

1. Specify the person for whom this typing is being done: ☐ Recipient — final typing ☐ Donor

HLA Typing by DNA Technology

2. Was documentation submitted to the CIBMTR? (e.g. lab report) ☐ Yes ☐ No

HLA Alleles Defined by DNA Technology (e.g., Sequence Specific Oligonucleotide Probe (SSOP) typing, Sequence Specific Primer (SSP) typing or Sequence Based (SBT) typing.)

DNA technology can be used to type for a single allele, combinations of alleles (allele strings) or a "generic" allele designation which is similar to a serologic typing result. For this reason, the number of digits, as well as the number of alleles, for reporting will vary.

Laboratories may use " / " , " – " or a combination of numbers and letters on the typing report as a shorthand notation for the results. Transcribe the information onto the form as directly as possible. The letters are called allele codes, and will be 1 or more characters in length which represent a combination of possible alleles at a locus. The same allele combination may be reported several different ways (e.g., DRB1*01:01 or 01:02, DRB1*01:01/01:02, DRB1*01:01/02, or DRB1*01:AB).

There will be two alleles reported for each locus, unless the individual is presumed homozygous (i.e., carries two copies of the same allele) at a locus. Transcribe the first allele designation in the first box, and the second allele designation in the second box. If the person is homozygous, leave the second box blank.

Class I

3. Locus A
   - ☐ Known →
   - ☐ Unknown

4. First A* allele designations	
Second A* allele designations	

5. Locus B
   - ☐ Known →
   - ☐ Unknown

6. First B* allele designations	
Second B* allele designations	

7. Locus C
   - ☐ Known →
   - ☐ Unknown

8. First C* allele designations	
Second C* allele designations	

Class II

9. Locus DRB1

☐ Known → 10. First DRB1* allele designations

☐ Unknown

Second DRB1* allele designations

Class II (Optional)

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

11. Locus DRB3

☐ Known → 12. First DRB3* allele designations

☐ Unknown

Second DRB3* allele designations

13. Locus DRB4

☐ Known → 14. First DRB4* allele designations

☐ Unknown

Second DRB4* allele designations

15. Locus DRB5

☐ Known → 16. First DRB5* allele designations

☐ Unknown

Second DRB5* allele designations

17. Locus DQB1

☐ Known → 18. First DQB1* allele designations

☐ Unknown

Second DQB1* allele designations

19. Locus DPB1

☐ Known → 20. First DPB1* allele designations

☐ Unknown

Second DPB1* allele designations

21. Locus DQA1

☐ Known → 22. First DQA1* allele designations

☐ Unknown

Second DQA1* allele designations

23. Locus DPA1

☐ Known → 24. First DPA1* allele designations

☐ Unknown

Second DPA1* allele designations

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.

Instructions for the use of the "X" Antigen Specificity for Typing By Serology

Each HLA locus has a serologically defined "X" antigen specificity: AX, BX, CX, DRX, DPX, and DQX. At this time an "X" specificity is defined as "unknown but known to be different from the other antigen at that locus." This is different from a blank specificity, which is defined as "unknown but assumed to be the same as the other antigen at that locus." When comparisons between recipient and donor antigens involve an "X" or "blank" specificity, the "X" or "blank" is assumed to be homozygous for the antigen reported at the locus. In other words, the search algorithm treats typings containing "blank" or "X" antigens in the same manner as known homozygous typings.

A Antigens

25. Number of antigens provided:

☐ One ***- Go to question 26, then continue with question 28***

☐ Two ***- Go to questions 26-27***

26. Specificity – 1st antigen

☐ A1

☐ A2

☐ A203

☐ A210

☐ A3

- ☐ A9
- ☐ A10
- ☐ A11
- ☐ A19
- ☐ A23(9)
- ☐ A24(9)
- ☐ A2403
- ☐ A25(10)
- ☐ A26(10)
- ☐ A28
- ☐ A29(19)
- ☐ A30(19)
- ☐ A31(19)
- ☐ A32(19)
- ☐ A33(19)
- ☐ A34(10)
- ☐ A36
- ☐ A43
- ☐ A66(10)
- ☐ A68(28)
- ☐ A69(28)
- ☐ A74(19)
- ☐ A80
- ☐ AX

27. Specificity – 2nd antigen

- ☐ A1
- ☐ A2
- ☐ A203
- ☐ A210
- ☐ A3
- ☐ A9
- ☐ A10
- ☐ A11
- ☐ A19
- ☐ A23(9)
- ☐ A24(9)
- ☐ A2403
- ☐ A25(10)
- ☐ A26(10)
- ☐ A28
- ☐ A29(19)
- ☐ A30(19)

- ☐ A31(19)
- ☐ A32(19)
- ☐ A33(19)
- ☐ A34(10)
- ☐ A36
- ☐ A43
- ☐ A66(10)
- ☐ A68(28)
- ☐ A69(28)
- ☐ A74(19)
- ☐ A80
- ☐ AX

B Antigens

28. Number of antigens provided:
    - ☐ One ***- Go to question 29, then continue with question 31***
    - ☐ Two ***- Go to questions 29-30***

29. Specificity – 1st antigen
    - ☐ B5
    - ☐ B7
    - ☐ B703
    - ☐ B8
    - ☐ B12
    - ☐ B13
    - ☐ B14
    - ☐ B15
    - ☐ B16
    - ☐ B17
    - ☐ B18
    - ☐ B21
    - ☐ B22
    - ☐ B27
    - ☐ B2708
    - ☐ B35
    - ☐ B37
    - ☐ B38(16)
    - ☐ B39(16)
    - ☐ B3901
    - ☐ B3902
    - ☐ B40
    - ☐ B4005
    - ☐ B41
    - ☐ B42

- ☐ B44(12)
- ☐ B45(12)
- ☐ B46
- ☐ B47
- ☐ B48
- ☐ B49(21)
- ☐ B50(21)
- ☐ B51(5)
- ☐ B5102
- ☐ B5103
- ☐ B52(5)
- ☐ B53
- ☐ B54(22)
- ☐ B55(22)
- ☐ B56(22)
- ☐ B57(17)
- ☐ B58(17)
- ☐ B59
- ☐ B60(40)
- ☐ B61(40)
- ☐ B62(15)
- ☐ B63(15)
- ☐ B64(14)
- ☐ B65(14)
- ☐ B67
- ☐ B70
- ☐ B71(70)
- ☐ B72(70)
- ☐ B73
- ☐ B75(15)
- ☐ B76(15)
- ☐ B77(15)
- ☐ B78
- ☐ B81
- ☐ B82
- ☐ BX

30. Specificity – 2nd antigen

- ☐ B5
- ☐ B7
- ☐ B703
- ☐ B8
- ☐ B12

- ☐ B13
- ☐ B14
- ☐ B15
- ☐ B16
- ☐ B17
- ☐ B18
- ☐ B21
- ☐ B22
- ☐ B27
- ☐ B2708
- ☐ B35
- ☐ B37
- ☐ B38(16)
- ☐ B39(16)
- ☐ B3901
- ☐ B3902
- ☐ B40
- ☐ B4005
- ☐ B41
- ☐ B42
- ☐ B44(12)
- ☐ B45(12)
- ☐ B46
- ☐ B47
- ☐ B48
- ☐ B49(21)
- ☐ B50(21)
- ☐ B51(5)
- ☐ B5102
- ☐ B5103
- ☐ B52(5)
- ☐ B53
- ☐ B54(22)
- ☐ B55(22)
- ☐ B56(22)
- ☐ B57(17)
- ☐ B58(17)
- ☐ B59
- ☐ B60(40)
- ☐ B61(40)
- ☐ B62(15)
- ☐ B63(15)
- ☐ B64(14)
- ☐ B65(14)

- ☐ B67
- ☐ B70
- ☐ B71(70)
- ☐ B72(70)
- ☐ B73
- ☐ B75(15)
- ☐ B76(15)
- ☐ B77(15)
- ☐ B78
- ☐ B81
- ☐ B82
- ☐ BX

Optional Antigen Reporting

Antigens Defined by Serologic Typing

C Antigens

31. Number of antigens provided:
    - ☐ One ***- Go to question 32, then continue with question 34***
    - ☐ Two ***- Go to questions 32-33***

32. Specificity – 1st antigen
    - ☐ Cw1
    - ☐ Cw2
    - ☐ Cw3
    - ☐ Cw4
    - ☐ Cw5
    - ☐ Cw6
    - ☐ Cw7
    - ☐ Cw8
    - ☐ Cw9(w3)
    - ☐ Cw10(w3)
    - ☐ CX

33. Specificity – 2nd antigen
    - ☐ Cw1
    - ☐ Cw2
    - ☐ Cw3
    - ☐ Cw4
    - ☐ Cw5
    - ☐ Cw6

- ☐ Cw7
- ☐ Cw8
- ☐ Cw9(w3)
- ☐ Cw10(w3)
- ☐ CX

Bw Specificity

34. Specificity Bw4 present? ☐ Yes ☐ No

35. Specificity Bw6 present? ☐ Yes ☐ No

DR Antigens

36. Number of antigens provided:

- ☐ One ***- Go to question 37, then continue with question 39***
- ☐ Two ***- Go to questions 37-38***

37. Specificity – 1st antigen

- ☐ DR1
- ☐ DR103
- ☐ DR2
- ☐ DR3
- ☐ DR4
- ☐ DR5
- ☐ DR6
- ☐ DR7
- ☐ DR8
- ☐ DR9
- ☐ DR10
- ☐ DR11(5)
- ☐ DR12(5)
- ☐ DR13(6)
- ☐ DR14(6)
- ☐ DR1403
- ☐ DR1404
- ☐ DR15(2)
- ☐ DR16(2)
- ☐ DR17(3)
- ☐ DR18(3)
- ☐ DRX

38. Specificity – 2nd antigen

- ☐ DR1
- ☐ DR103
- ☐ DR2

- ☐ DR3
- ☐ DR4
- ☐ DR5
- ☐ DR6
- ☐ DR7
- ☐ DR8
- ☐ DR9
- ☐ DR10
- ☐ DR11(5)
- ☐ DR12(5)
- ☐ DR13(6)
- ☐ DR14(6)
- ☐ DR1403
- ☐ DR1404
- ☐ DR15(2)
- ☐ DR16(2)
- ☐ DR17(3)
- ☐ DR18(3)
- ☐ DRX

DR51 Antigen

39. Specificity DR51 present? ☐ Yes ☐ No

DR52 Antigen

40. Specificity DR52 present? ☐ Yes ☐ No

DR53 Antigen

41. Specificity DR53 present? ☐ Yes ☐ No

DQ Antigens

42. Number of antigens provided:
   - ☐ One ***- Go to question 43, then continue with question 45***
   - ☐ Two ***- Go to questions 43-44***

43. Specificity – 1st antigen
   - ☐ DQ1
   - ☐ DQ2
   - ☐ DQ3
   - ☐ DQ4
   - ☐ DQ5(1)
   - ☐ DQ6(1)
   - ☐ DQ7(3)
   - ☐ DQ8(3)

☐ DQ9(3)
☐ DQX

44. Specificity – 2nd antigen
☐ DQ1
☐ DQ2
☐ DQ3
☐ DQ4
☐ DQ5(1)
☐ DQ6(1)
☐ DQ7(3)
☐ DQ8(3)
☐ DQ9(3)
☐ DQX

DP Antigens

45. Number of antigens provided:
☐ One ***- Go to question 46, then continue with signature line***
☐ Two ***- Go to questions 46-47***

46. Specificity – 1st antigen
☐ DPw1
☐ DPw2
☐ DPw3
☐ DPw4
☐ DPw5
☐ DPw6
☐ DPX

47. Specificity – 2nd antigen
☐ DPw1
☐ DPw2
☐ DPw3
☐ DPw4
☐ DPw5
☐ DPw6
☐ DPX

First Name (person completing form):_____

Last Name: _____

E-mail address: _____

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

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Infectious Disease Markers

Registry Use Only
Sequence Number:

Date Received:

OMB No: 0915-0310
Expiration Date: 1/31/2020

CIBMTR Center Number: ___ ___ ___ ___ ___

CIBMTR Research ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

HCT type (check all that apply): ☐ Allogeneic, unrelated ☐ Allogeneic, related

Product type (check all that apply):
☐ Bone marrow ☐ PBSC ☐ Single cord blood unit ☐ Multiple cord blood units ☐ Other product. Specify: _____

Product Identifiers:

NMDP cord blood unit ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Non-NMDP unrelated donor ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Non-NMDP cord blood unit ID: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

GRID (optional): __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

ISBT DIN: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Registry or UCB Bank ID: __ __ __ __

Donor DOB: __ __ __ __ / __ __ / __ __
YYYY MM DD

Donor Age: __ __ ☐ Months (use only if less than 1 year old) ☐ Years

Donor Sex: ☐ Male ☐ Female

CIBMTR Center Number: ___ ___ ___ ___ ___ CIBMTR Recipient ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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. Who is being tested for IDMs?
   - ☐ Donor IDM (bone marrow or PBSC)
   - ☐ Maternal IDM (cord blood)
   - ☐ Cord blood unit IDM

Infectious Disease Marker (report final test results)

Hepatitus B Virus (HBV)

2. HBsAg: (hepatitus B surface antigen)
   - ☐ Reactive → 3. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Non-reactive → 3. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Not done

4. Anti HBc: (hepatitus B core antibody)
   - ☐ Reactive → 5. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Non-reactive → 5. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Not done

6. Was FDA licensed NAAT testing for HBV performed?
   - ☐ Positive → 7. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Negative → 7. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Not done

Hepatitis C Virus (HCV)

8. Anti-HCV: (hepatitis C antibody)
   - ☐ Reactive → 9. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Non-reactive → 9. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
   - ☐ Not done

10. Was FDA licensed NAAT testing for HCV performed?
    - ☐ Yes → 11. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
    - ☐ No
    - ☐ Not done

Human Immunodeficiency Virus (HIV)

12. HIV-1 p24 antigen:
    - ☐ Reactive → 13. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
    - ☐ Non-reactive → 13. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
    - ☐ Not done
    - ☐ Not reported

14. Was FDA licensed NAAT testing for HIV-1 performed?

- ☐ Yes → 15. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ No
- ☐ Not done

16. 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.

- ☐ Reactive → 17. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Non-reactive → 17. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Not done
- ☐ Not reported

Chagas

18. Chagas testing

- ☐ Positive → 19. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Negative → 19. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Not done

Herpes simplex virus (HSV)

20. Anti-HSV (Herpes simplex virus antibody)

- ☐ Positive → 21. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Negative → 21. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Not done

Epstein-Barr virus (EBV)

22. Anti-EBV (Epstein-Barr virus antibody)

- ☐ Positive → 23. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Negative → 23. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Inconclusive → 23. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Not done

Varicella zoster virus (VZV)

24. Anti-VZV (Varicella zoster virus antibody)

- ☐ Positive → 25. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Negative → 25. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)
- ☐ Not done

Other Infectious Disease Marker

26. Other infectious disease marker, specify:
- ☐ Yes →
- ☐ No

27. Date sample collected: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)

28. Specify test and method: _____

29. Specify test results: _____

Copy questions 27 - 29 to report multiple other infectious disease markers

First Name: _____

Last Name: _____

E-mail address: _____

Date: __ __ __ __ / __ __ / __ __ (YYYY / MM / DD)