



Hematopoietic Cellular Transplant (HCT) Infusion

Registry Use Only
 Sequence Number: _____

Date Received: _____

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, in combination with the IDM Form 2004 and HLA Typing Form 2005, 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: 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

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 →
- Not done

45. Total nucleated cells: _____ • _____ x 10 _____

46. Viability of cells

- Done →
- Not done
- Unknown

47. Viability of cells: _____ %

48. Method of testing cell viability:

- Flow cytometry based
- Trypan blue
- Other method →

49. Specify other method: _____

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 nondiphtheria 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 mucilaginosus
 - 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 guilliermondi
 - 202 Candida krusei
 - 207 Candida lusitanae
 - 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 →
 No

1174. In the Medical Director's judgment, was the adverse event a direct result of the infusion?

- Yes No

118. Hives

- Yes →
 No

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

- Yes No

120. Hypertension

- Yes →
 No

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

- Yes No

122. Hypotension

- Yes →
 No

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

- Yes No

124. Hypoxia requiring oxygen (O₂) support

- Yes →
 No

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

- Yes No

126. Nausea

- Yes →
 No

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

- Yes No

128. Rigors, mild

- Yes →
 No

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

- Yes No

130. Rigors, severe

- Yes →
 No

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

- Yes No

132. Shortness of breath (SOB)

- Yes →
- No

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

- Yes
- No

134. Tachycardia

- Yes →
- No

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

- Yes
- No

136. Vomiting

- Yes →
- No

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

- Yes
- No

138. Other expected AE

- Yes →
- No

139. Specify other expected AE: _____

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

- Yes
- No

141. Other unexpected AE

- Yes →
- No

142. Specify other unexpected AE: _____

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

- Yes
- No

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 →
- No

164. Date of collection: ____ / ____ / ____
 YYYY MM DD

165. Number of units: ____

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

- Autologous transfusions →
- Allogenic transfusions →
- No

167. Specify number of autologous units: ____

168. Specify number of allogenic units: ____

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

- Yes →
- No - **Go to signature line**

170. Specify cause of death: _____

First Name (person completing form): _____

Last Name: _____

E-mail address: _____

Date: ____ / ____ / ____
 YYYY MM DD



Confirmation of HLA Typing

Registry Use Only

Sequence Number: _____

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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 DDDonor Age: __ __ Months (use only if less than 1 year old) YearsDonor 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 → Unknown

10. First DRB1* allele designations

Second DRB1* allele designations

Class II (Optional)**Please provide the optional allele information if it is available from your laboratory**

11. Locus DRB3

 Known → Unknown

12. First DRB3* allele designations

Second DRB3* allele designations

13. Locus DRB4

 Known → Unknown

14. First DRB4* allele designations

Second DRB4* allele designations

15. Locus DRB5

 Known → Unknown

16. First DRB5* allele designations

Second DRB5* allele designations

17. Locus DQB1

 Known → Unknown

18. First DQB1* allele designations

Second DQB1* allele designations

19. Locus DPB1

- Known →
- Unknown

20. First DPB1* allele designations

Second DPB1* allele designations

21. Locus DQA1

- Known →
- Unknown

22. First DQA1* allele designations

Second DQA1* allele designations

23. Locus DPA1

- Known →
- Unknown

24. First DPA1* allele designations

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

CIBMTR Center Number: _____

CIBMTR Research ID: _____

- 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?
35. Specificity Bw6 present?

- Yes No
 Yes No

DR Antigen

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



Infectious Disease Markers

Registry Use Only

Sequence Number: _____

Date Received: _____

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, 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: 1/31/2020

CIBMTR Center Number: _____

CIBMTR Research ID: _____

Event date: __ __ / __ __ / __ __
 YYYY MM DDHCT 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 DDDonor Age: __ __ Months (use only if less than 1 year old) YearsDonor Sex: Male Female

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)

Hepatitis B Virus (HBV)

2. HBsAg: (hepatitis B surface antigen)
 Reactive →
 Non-reactive →
 Not done

3. Date sample collected: ___/___/___
 YYYY MM DD

4. Anti HBc: (hepatitis B core antibody)
 Reactive →
 Non-reactive →
 Not done

5. Date sample collected: ___/___/___
 YYYY MM DD

6. Was FDA licensed NAAT testing for HBV performed?
 Positive →
 Negative →
 Not done

7. Date sample collected: ___/___/___
 YYYY MM DD

Hepatitis C Virus (HCV)

8. Anti-HCV: (hepatitis C antibody)
 Reactive →
 Non-reactive →
 Not done

9. Date sample collected: ___/___/___
 YYYY MM DD

10. Was FDA licensed NAAT testing for HCV performed?
 Yes →
 No
 Not done

11. Date sample collected: ___/___/___
 YYYY MM DD

Human Immunodeficiency Virus (HIV)

12. HIV-1 p24 antigen:
 Reactive →
 Non-reactive →
 Not done
 Not reported

13. Date sample collected: ___/___/___
 YYYY MM DD

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

- Yes →
- No →
- Not done →

15. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD

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 →
- Non-reactive →
- Not done →
- Not reported →

17. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD**Chagas**

18. Chagas testing

- Positive →
- Negative →
- Not done →

19. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD**Herpes simplex virus (HSV)**

20. Anti-HSV (Herpes simplex virus antibody)

- Positive →
- Negative →
- Not done →

21. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD**Epstein-Barr virus (EBV)**

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

- Positive →
- Negative →
- Inconclusive →
- Not done →

23. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD**Varicella zoster virus (VZV)**

24. Anti-VZV (Varicella zoster virus antibody)

- Positive →
- Negative →
- Not done →

25. Date sample collected: __ __ __ __ / __ __ / __ __
YYYY MM DD

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