**CIBMTR Use Only**

OMB No: 0915-0310

Expiration Date: 10/31/2022

**Public Burden Statement:** The purpose of the data collection is to fulfill the legislative mandate to establish and maintain a standardized database of allogeneic marrow and cord blood transplants performed in the United States or using a donor from the United States. The data collected also meets the C.W. Bill Young Cell Transplantation Program requirements to provide relevant scientific information not containing individually identifiable information available to the public in the form of summaries and data sets. 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 information collection is 0915-0310 and it is valid until 10/31/2022. This information collection is voluntary under The Stem Cell Therapeutic and Research Act of 2005, Public Law (Pub. L.) 109–129, as amended by the Stem Cell Therapeutic and Research Reauthorization Act of 2010, Public Law 111–264 (the Act) and the Stem Cell Therapeutic and Research Reauthorization Act of 2015, Public Law 114-104. Public reporting burden for this collection of information is estimated to average 0.68 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 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

Sequence Number:

Date Received:

**Center Identification**

CIBMTR Center Number: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

EBMT Code (CIC): \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Recipient Identification**

CIBMTR Research ID (CRID): \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

Event date: \_\_ \_\_ \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

YYYY MM DD

Recipient Information

1. Date of birth: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

1. Sex

* Male
* Female

1. Ethnicity

* Hispanic or Latino
* Not Hispanic or Latino
* Not applicable (not a resident of the USA)
* Unknown

1. Race (check all that apply)

* White – Go to question 5
* Black or African American– Go to question 5
* Asian– Go to question 5
* American Indian or Alaska Native– Go to question 5
* Native Hawaiian or Other Pacific Islander– Go to question 5
* Not reported– Go to question 6
* Unknown– Go to question 6

1. 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

Country of primary residence

|  |  |  |
| --- | --- | --- |
| * Afghanistan * Aland Islands * Albania * Algeria * American Samoa * Andorra * Angola * Anguilla * Antarctica * Antigua and Barbuda * Argentina * Armenia * Aruba * Australia * Austria * Azerbaijan * Bahamas * Bahrain * Bangladesh * Barbados * Belarus * Belgium * Belize * Benin * Bermuda * Bhutan * Bolivia * Bonaire, Sint Eustatius and Saba * Bosnia and Herzegovina * Botswana * Bouvet Island * Brazil - G***o to question 7*** * British Indian Ocean Territory * British Virgin Islands * Brunei Darussalam * Bulgaria * Burkina Faso * Burundi * Cambodia * Cameroon * Canada - G***o to question 8*** * Cape Verde * Cayman Islands * Central African Republic * Chad * Chile * China * Christmas Island * Cocos (Keeling) Islands * Colombia * Comoros * Congo, Democratic Republic of the * Congo, Republic of the * Cook Islands * Costa Rica * Cote d’Ivoire * Croatia * Cuba * Curacao * Cyprus * Czech Republic * Denmark * Djibouti * Dominica * Dominican Republic * Ecuador * Egypt * El Salvador * Equatorial Guinea * Eritrea * Estonia * Ethiopia * Falkland Islands * Faroe Islands * Fiji * Finland * France * French Guiana * French Polynesia * French Southern Territories * Gabon * Gambia * Georgia * Germany | * Ghana * Gibraltar * Greece * Greenland * Grenada * Guadeloupe * Guam * Guatemala * Guernsey * Guinea * Guinea-Bissau * Guyana * Haiti * Heard Island and McDonald Islands * Holy See * Honduras * Hong Kong * Hungary * Iceland * India * Indonesia * Iran * Iraq * Ireland * Isle of Man * Israel * Italy * Jamaica * Japan * Jersey * Jordan * Kazakhstan * Kenya * Kiribati * Kuwait * Kyrgyzstan * Laos * Latvia * Lebanon * Lesotho * Liberia * Libya * Liechtenstein * Lithuania * Luxembourg * Macau * Macedonia * Madagascar * Malawi * Malaysia * Maldives * Mali * Malta * Marshall Islands * Martinique * Mauritania * Mauritius * Mayotte * Mexico * Micronesia * Moldova * Monaco * Mongolia * Montenegro * Montserrat * Morocco * Mozambique * Myanmar * Namibia * Nauru * Nepal * Netherlands * Netherlands Antilles * New Caledonia * New Zealand * Nicaragua * Niger * Nigeria * Niue * Norfolk Island * North Korea * Northern Mariana Islands * Norway * Oman * Pakistan | * Palau * Palestine, State of * Panama * Papua New Guinea * Paraguay * Peru * Philippines * Pitcairn Islands * Poland * Portugal * Puerto Rico * Qatar * Reunion * Romania * Russia * Rwanda * Saint Barthelemy * Saint Helena * Saint Kitts and Nevis * Saint Lucia * Saint Martin, French * Saint Pierre and Miquelon * Saint Vincent and the Grenadines * Samoa * San Marino * Sao Tome and Principe * Saudi Arabia * Senegal * Serbia * Seychelles * Sierra Leone * Singapore * Sint Maarten, Dutch * Slovak Republic * Slovenia * Solomon Islands * Somalia * South Africa * South Georgia and the South Sandwich Islands * South Korea * South Sudan * Spain * Sri Lanka * Sudan * Suriname * Svalbard and Jan Mayen * Swaziland * Sweden * Switzerland * Syria * Taiwan * Tajikistan * Tanzania * Thailand * Timor-Leste * Togo * Tokelau * Tonga * Trinidad and Tobago * Tunisia * Turkey * Turkmenistan * Turks and Caicos Islands * Tuvalu * Uganda * Ukraine * United Arab Emirates * United Kingdom (England, Wales, Scotland, Northern Ireland) * United States - G***o to question 9*** * United States Minor Outlying Islands * United States Virgin Islands * Uruguay * Uzbekistan * Vanuatu * Venezuela * Vietnam * Wallis and Futuna Islands * Western Sahara * Yemen * Zambia * Zimbabwe |

1. State of residence of recipient (for residents of Brazil) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - Go to question 10

|  |  |  |
| --- | --- | --- |
| * Acre * Alagoas * Amapá * Amazonas * Bahia * Ceará * Distrito Federal * Espírito Santo * Goiás | * Maranhão * Mato Grosso * Mato Grosso do Sul * Minas Gerais * Pará * Paraíba * Paraná * Pernambuc * Piauí | * Rio de Janeiro * Rio Grande do Norte * Rio Grande do Sul * Rondônia * Roraima * Santa Catarina * São Paulo * Sergipe * Tocantins |

1. Province or territory of residence of recipient (for residents of Canada) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_- Go to question 10

|  |  |  |
| --- | --- | --- |
| **Provinces**   * Alberta * British Columbia * Manitoba * New Brunswick * Newfoundland and Labrador | * Nova Scotia * Ontario * Prince Edward Island * Quebec * Saskatchewan | **Territories**   * Northwest Territories * Nunavut * Yukon |

1. State of residence of recipient (for residents of USA) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. NMDP Recipient ID (RID): \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_
2. Zip or postal code for place of recipient’s residence (USA and Canada recipients only): \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_ \_\_\_ \_\_\_ \_\_\_

1. Specify blood type (of recipient) (For allogeneic HCTs only)

 A

 B

 AB

 O

1. Specify Rh factor (of recipient) (For allogeneic HCTs only)

 Positive

 Negative

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

* Yes (recipient consented) – Go to question 15
* No (recipient declined) - Go to question 18
* Not approached - Go to question 18
* Not applicable (center not participating) - Go to question 18

1. Date form was signed: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

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

* Yes – Go to question 17
* No – Go to question 18

1. Research sample recipient ID: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_
2. Is the recipient participating in a clinical trial? (clinical trial sponsors that use CIBMTR forms to capture outcomes data)

 Yes - ***Go to question 19***

 No – ***Go to question 24***

1. Study Sponsor

* BMT CTN – Go to question 21
* RCI BMT – Go to question 21
* PIDTC – Go to question 21
* USIDNET – Go to question 22
* COG – Go to question 22
* Other sponsor – Go to question 20

1. Specify other sponsor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***- Go to question 22***
2. Study ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Subject ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Specify the ClinicalTrials.gov identification number: NCT \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**Copy questions 19-23 to report participation in more than one study.**

Hematopoietic Cellular Transplant (HCT) and Cellular Therapy

1. 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 – Go to question 25
* No – Go to question 26

1. Specify subsequent HCT planned

* Autologous
* Allogeneic

1. Has the recipient ever had a prior HCT?

 Yes – Go to question 27

 No – Go to question 38

1. Specify the number of prior HCTs: \_\_\_ \_\_\_
2. Were all prior HCTs reported to the CIBMTR?

* Yes – Go to question 33
* No – Go to question 29
* Unknown – Go to question 33

Copy and complete questions 29- 32 to report all prior HCTs that have not yet been reported to the CIBMTR

1. Date of the prior HCT: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ 🞏 Date estimated

YYYY MM DD

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

* Yes – Go to question 31
* No – Go to question 32

**Specify the institution that performed the last HCT**

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What was the HPC source for the prior HCT? *(check all that apply)*

* Autologous
* Allogeneic, unrelated
* Allogeneic, related

1. Reason for current HCT

* Graft failure / insufficient hematopoietic recovery – Go to question 34
* Persistent primary disease– Go to question 38
* Recurrent primary disease– Go to question 35
* Planned subsequent HCT, per protocol– Go to question 38
* New malignancy (including PTLD and EBV lymphoma) – Go to question 36
* Insufficient chimerism– Go to question 38
* Other– Go to question 37

1. Date of graft failure / rejection: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ – Go to question 38

YYYY MM DD

1. Date of relapse: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ – Go to question 38

YYYY MM DD

1. Date of secondary malignancy: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ – Go to question 38

YYYY MM DD

1. Specify other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - Go to question 38
2. Has the recipient ever had a prior cellular therapy? (do not include DLIs)

 Yes – Go to question 39

 No – Go to question 44

Unknown– Go to question 44

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

* Yes – Go to question 44
* No – Go to question 40
* Unknown– Go to question 44

**Copy and complete questions 40-43 to report all prior cellular therapies that have not yet been reported to the CIBMTR**

1. Date of the prior cellular therapy: \_\_ \_\_ \_\_ \_\_ -- \_\_ \_\_ -- \_\_ \_\_

YYYY MM DD

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

* Yes – Go to question 42
* No – Go to question 43

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:

State:

Country:

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

* Autologous
* Allogeneic, unrelated
* Allogeneic, related

Donor Information

1. Multiple donors?

* Yes – Go to question 45
* No - Go to question 46

1. Specify number of donors: \_\_\_ \_\_\_

**To report more than one donor, copy questions 46-82 and complete for each donor.**

1. Specify donor

* Autologous
* Allogeneic, related
* Allogeneic, unrelated

Specify product type (check all that apply)

* Bone marrow
* PBSC
* Single cord blood unit
* Other product– Go to question 48

1. Specify other product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is the product genetically modified? ***If autologous, go to question 77. If allogeneic related, go to question 50. If allogeneic unrelated, go to question 54.***

* Yes
* No

1. 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 51
* HLA-mismatched relative– ***Go to question 51***

1. Specify the biological relationship of the donor to the recipient

* Mother
* Father
* Child
* Sibling
* Fraternal twin
* Maternal aunt
* Maternal uncle
* Maternal cousin
* Paternal aunt
* Paternal uncle
* Paternal cousin
* Grandparent
* Grandchild
* Other biological relative – Go to question 52

Specify other biological relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_– Go to question 53

Degree of mismatch (related donors only)

* HLA-mismatched 1 allele– Go to question 55
* HLA-mismatched >2 alleles (does include haplo-identical donor) – Go to question 55

1. Specify unrelated donor type

* HLA matched unrelated
* HLA mismatched unrelated

1. Did NMDP / Be the Match facilitate the procurement, collection, or transportation of the product?

* Yes
* No

1. Was this donor used for any prior HCTs? (for this recipient)

* Yes
* No

1. Global Registration Identifier for Donors (GRID): \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**NMDP donor, go to question 72**

**Non-NMDP unrelated donor, go to question 63**

1. NMDP cord blood unit ID: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ – Go to question 72
2. Registry donor ID: (not applicable for related donors)

\_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ - ***Go to question 63***

1. Non-NMDP cord blood unit ID: (include related and autologous CBUs)

\_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ - ***Go to question 61***

1. Is the CBU ID also the ISBT DIN number?

* Yes – Go to question 63
* No – Go to question 62
* Unknown– Go to question 63

1. Specify the ISBT DIN number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Registry or UCB Bank ID: \_\_\_ \_\_\_ \_\_\_ \_\_\_ - If ‘Other registry’ go to 64, otherwise go to question 65
3. Specify other Registry or UCB Bank: - ***Go to question 65***
4. Donor date of birth

* Known – Go to question 66
* Unknown – Go to question 67

1. Donor date of birth: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ - ***Go to question 69***

YYYY MM DD

1. Donor age

* Known – Go to question 68

 Unknown – Go to question 69

1. Donor age: \_\_\_ \_\_\_  Months (use only if less than 1 year old)

 Years

Donor sex

* Male
* Female

1. Specify blood type (donor) (non-NMDP allogeneic donors only)

* A
* B
* AB
* O

1. Specify Rh factor (donor) (non-NMDP allogeneic donors only)

* Positive
* Negative

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

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

1. 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) – Go to question 74
* No (donor declined) - Go to question 77
* Not approached - Go to question 77
* Not applicable (center not participating) - Go to question 77

1. Date form was signed: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

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

* Yes – Go to question 76
* No – Go to question 77

1. Research sample donor ID: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

1. Specify number of products infused from this donor: \_\_\_ \_\_\_
2. Specify the number of these products intended to achieve hematopoietic engraftment: \_\_\_ \_\_\_

**Questions 79-80 are for autologous HCT recipients only.**

1. 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***– Go to question 80***

1. Specify other agent: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of product: (gene therapy recipients)

* Other name

Specify other name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To report more than one donor, copy questions 46-82 and complete for each donor.

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

1. What scale was used to determine the recipient’s functional status?

* Karnofsky (recipient age ≥ 16 years) – Go to question 84
* Lansky (recipient age ≥ 1 year and < 16 years) – Go to question 85

**Performance score prior to the preparative regimen:**

1. Karnofsky Scale (recipient age ≥ 16 years)

* 100 Normal; no complaints; no evidence of disease - ***Go to question 86***
* 90 Able to carry on normal activity - ***Go to question 86***
* 80 Normal activity with effort - ***Go to question 86***
* 70 Cares for self; unable to carry on normal activity or to do active work - ***Go to question 86***
* 60 Requires occasional assistance but is able to care for most needs - ***Go to question 86***
* 50 Requires considerable assistance and frequent medical care - ***Go to question 86***
* 40 Disabled; requires special care and assistance - ***Go to question 86***
* 30 Severely disabled; hospitalization indicated, although death not imminent - ***Go to question 86***
* 20 Very sick; hospitalization necessary - ***Go to question 86***
* 10 Moribund; fatal process progressing rapidly - ***Go to question 86***

1. Lansky Scale (recipient age ≥ 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

1. Recipient CMV-antibodies (IgG or Total)

* Reactive
* Non-reactive
* Indeterminate
* Not done

Comorbid Conditions

1. Has the patient been infected with COVID-19 (SARS-CoV-2) based on a positive test result at any time prior to the start of the preparative regimen / infusion?

* Yes – ***Go to question 88***
* No – ***Go to question 90***

1. Did the patient require hospitalization for management of COVID-19 (SARS-CoV-2) infection?

* Yes – ***Go to question 89***
* No – ***Go to question 90***

1. Was mechanical ventilation used for COVID-19 (SARS-CoV-2) infection?

* Yes
* No

1. Was a vaccine for COVID-19 (SARS-CoV-2) received at any time prior to the start of the preparative regimen / infusion?

* Yes – ***Go to question 91***
* No – ***Go to question 97***
* Unknown – ***Go to question 97***

1. Select dose(s) received *(check all that apply)*

* One dose *(without planned second dose)* – ***Go to question 92***
* First dose *(with planned second dose)* – ***Go to question 93***
* Second dose – ***Go to question 94***

1. Date of one dose received: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ □Date estimated

YYYY MM DD

1. Date of first dose received: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ □Date estimated

YYYY MM DD

1. Date of second dose received: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_ □Date estimated

YYYY MM DD

1. Specify vaccine type:

* AstraZeneca
* Johnson & Johnson
* Moderna
* Novavax
* Pfizer-BioNTECH
* Other type – **Go to question 96**

1. Specify other type: \_\_\_\_\_\_\_\_\_\_
2. Is there a history of mechanical ventilation (excluding COVID-19 (SARS-CoV-2))?

* Yes
* No

1. Is there a history of invasive fungal infection?

* Yes
* No

Glomerular filtration rate (GFR) before start of preparative regimen (pediatric only)

* Known- ***Go to question 100***
* Unknown- ***Go to question 101***

1. Glomerular filtration rate (GFR): \_\_ \_\_ \_\_ mL/min/1.732

Does the recipient have known complex congenital heart disease? (corrected or uncorrected) (excluding simple ASD, VSD, or PDA repair) **(pediatric only)**

* Yes
* No

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.)

* Yes- Go to question 103
* No- Go to question 109

Specify co-existing diseases or organ impairment (check all that apply)

* Arrhythmia - Any history of atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias requiring treatment
* 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
* Cerebrovascular disease -Any history of transient ischemic attack, subarachnoid hemorrhage or cerebral thrombosis, embolism, or hemorrhage
* Diabetes -Requiring treatment with insulin or oral hypoglycemic drugs in the last 4 weeks but not diet alone
* 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
* 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
* Hepatic, moderate/severe -Liver cirrhosis, bilirubin > 1.5 × upper limit of normal, or AST/ALT > 2.5 × upper limit of normal
* 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
* Inflammatory bowel disease -Any history of Crohn’s disease or ulcerative colitis requiring treatment
* 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 of higher for patients aged 18 years or younger
* Peptic ulcer -Any history of peptic (gastric or duodenal) ulcer confirmed by endoscopy or radiologic diagnosis requiring treatment
* 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
* 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
* 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
* Renal, moderate / severe -Serum creatinine > 2 mg/dL or > 177 μmol/L; on dialysis during the 4 weeks prior to transplant; OR prior renal transplantation -go to question 104
* Rheumatologic -Any history of a rheumatologic disease (e.g., systemic lupus erythematosis, rheumatoid arthritis, polymyositis, mixed connective tissue disease, or polymyalgia rheumatica, etc.) requiring treatment. (Do NOT include degenerative joint disease, osteoarthritis)
* Prior malignancy-Treated at any time point in the patient’s past history, other than the primary disease for which this infusion is being performed-go to question 105

1. Was the recipient on dialysis immediately prior to start of preparative regimen?

* Yes
* No
* Unknown

1. Specify prior malignancy (check all that apply)

* Breast cancer
* Central nervous system (CNS) malignancy (e.g., glioblastoma, astrocytoma)
* Gastrointestinal malignancy (e.g., colon, rectum, stomach, pancreas, intestine, esophageal)
* Genitourinary malignancy (e.g., kidney, bladder, ovary, testicle, genitalia, uterus, cervix, prostate)
* Leukemia (includes acute or chronic leukemia)
* Lung cancer
* Lymphoma (includes Hodgkin & non-Hodgkin lymphoma)
* MDS / MPN
* Melanoma
* Multiple myeloma / plasma cell disorder (PCD)
* Oropharyngeal cancer (e.g., tongue, buccal mucosa)
* Sarcoma
* Thyroid cancer
* Other skin malignancy (basal cell, squamous)***- go to question 106***
* Other hematologic malignancy -go to question 107
* Other solid tumor -go to question 108

1. Specify other skin malignancy: (prior) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Specify other hematologic malignancy: (prior) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Specify other solid tumor: (prior) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use results within 4 weeks prior to the start of the preparative regimen, report results from the test performed closest to the start date. Biomarkers according to the augmented HCT comorbidity index. (*Source: Biol Blood Marrow Transplant. 2015 Aug; 21(8): 1418–1424)*

1. Serum ferritin (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

* Known – Go to question 110
* Unknown – Go to question 113

1. \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ ng/mL (μg/L)

1. Date sample collected: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

1. Upper limit of normal for your institution: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_
2. Serum albumin (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

* Known – Go to question 114
* Unknown – Go to question 116

1. \_\_\_ \_\_\_ ● \_\_\_  g/dL

 g/L

1. Date sample collected: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

1. Platelets (within 4 weeks prior to the start of the preparative regimen, use result closest to the start date)

* Known – Go to question 117
* Unknown – Go to question 119

1. \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_  x 109/L (x 103/mm3)

 x 106/L

1. Were platelets transfused < 7 days before date of test?

* Yes
* No
* Unknown

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

* Yes- Go to question 120
* No- Go to question 123

1. Specify organ:

* Bowel
* Heart
* Kidney(s)
* Liver
* Lung(s)
* Pancreas
* Other organ- ***Go to question 121***

1. Specify other organ: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Year of prior solid organ transplant: \_\_\_ \_\_\_ \_\_\_ \_\_\_

YYYY

Copy and complete questions 120-122 for each prior solid organ transplant

Pre-HCT Preparative Regimen (Conditioning)

1. Height at initiation of pre-HCT preparative regimen: \_\_\_ \_\_\_ \_\_\_  inches

 centimeters

1. Actual weight at initiation of pre-HCT preparative regimen: \_\_\_ \_\_\_ \_\_\_ . \_\_\_  pounds

 kilograms

1. Was a pre-HCT preparative regimen prescribed?

* Yes – Go to question 126
* No – Go to question 132

1. Classify the recipient’s prescribed preparative regimen **(Allogeneic HCTs only)**

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

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

* Yes – Go to question 128
* No – Go to question 133

1. What was the prescribed radiation field?

* Total body – Go to question 129
* Total body by intensity-modulated radiation therapy (IMRT) – Go to question 129
* Total lymphoid or nodal regions – Go to question 129
* Thoracoabdominal region – Go to question 129

1. Total prescribed dose: (dose per fraction x total number of fractions) \_\_\_ \_\_\_ \_\_\_ \_\_\_ . \_\_\_  Gy

 cGy

1. Date started: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

1. Was the radiation fractionated?

* Yes – Go to question 132
* No – Go to question 133

1. Total number of fractions: \_\_\_ \_\_\_

**Indicate the total prescribed cumulative dose for the preparative regimen**

1. Drug (drop down list)

* Bendamustine
* Busulfan
* Carboplatin
* Carmustine (BCNU)
* CCNU (Lomustine)
* Clofarabine (Clolar)
* Cyclophosphamide (Cytoxan)
* 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 -go to question 134

1. Specify other drug: \_\_\_\_\_\_\_\_\_\_\_
2. Total prescribed dose: \_\_ \_\_ \_\_ \_\_ \_\_. \_\_  mg/m2

 mg/kg

 AUC (mg x h/L)

 AUC (µmol x min/L)

CSS (ng/mL)

1. Date started: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD

1. Specify administration (busulfan only)

* Oral
* IV
* Both

**Copy and complete question 133-137 to report each drug given for the preparative regimen**

Additional Drugs Given in the Peri-Transplant Period

1. ALG, ALS, ATG, ATS

* Yes – Go to question 139
* No – Go to question 142

1. Total prescribed dose: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ mg/kg
2. Specify source

* ATGAM (horse) – Go to question 142
* ATG – Fresenius (rabbit) – Go to question 142
* Thymoglobulin (rabbit) – Go to question 142
* Other – Go to question 141

1. Specify other source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Alemtuzumab (Campath)

* Yes – Go to question 143
* No – Go to question 144

1. Total prescribed dose: \_\_ \_\_ \_\_ \_\_ . \_\_  mg/m2

 mg/kg

mg

Defibrotide

* Yes
* No

KGF

* Yes
* No

Ursodiol

* Yes
* No

GVHD Prophylaxis

This section is to be completed for allogeneic HCTs only; autologous HCTs continue with question 150.

1. Was GVHD prophylaxis planned?

* Yes - Go to question 148
* No - Go to question 150

1. Specify drugs / intervention (check all that apply)

* Abatacept
* Anti CD 25 (Zenapax, Daclizumab, AntiTAC)
* Blinded randomized trial
* Bortezomib
* CD34 enriched (CD34+ selection)
* Corticosteroids (systemic)
* Cyclophosphamide (Cytoxan)
* Cyclosporine (CSA, Neoral, Sandimmune)
* Extra-corporeal photopheresis (ECP)
* Ex-vivo T-cell depletion
* Filgotinib
* Maraviroc
* Methotrexate (MTX) (Amethopterin)
* Mycophenolate mofetil (MMF) (CellCept)
* Ruxolotinib
* Sirolimus (Rapamycin, Rapamune)
* Tacrolimus (FK 506)
* Tocilizumab
* Other agent-go to question 149

1. Specify other agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (do not report ATG, campath)

Post-HCT Disease Therapy Planned as of Day 0

1. Is additional post-HCT therapy planned?

 Yes - Go to question 151

 No - Go to ***First Name***

Questions 151-152 are optional for non-U.S. centers

1. 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 (Gleevec, Glivec)
* 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- Go to question 152
* Unknown

1. Specify other therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Exposure: Potential Study Eligibility

Selecting any option(s) below may generate an additional supplemental form.

1. Specify if the recipient received any of the following (at any time prior to HCT / infusion) (check all that apply)

* Blinatumomab (Blincyto)
* Gemtuzumab ozogamicin (Mylotarg)
* Inotuzumab ozogamicin (Besponsa)
* Adienne Tepadina®
* Mogamulizumab (Poteligeo)
* None of the above

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:

Date: \_\_\_ \_\_\_ \_\_\_ \_\_\_ — \_\_\_ \_\_\_ — \_\_\_ \_\_\_

YYYY MM DD