

Legend: update addition



Recipient Death Data

Registry Use Only

Sequence Number: _____

Date Received: _____

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 0.05 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.

CIBMTR Center Number: _____

CIBMTR Research ID: _____

Event date: _____

YYYY MM DD

Malignancy

- New malignancy (*post-infusion*) – **Go to question 6.**
- Prior malignancy (*malignancy initially diagnosed prior to infusion, other than the malignancy for which the infusion was performed*) – **Go to question 6.**

Organ failure (not due to GVHD or infection)

- Cardiac failure – **Go to question 6.**
- Central nervous system (CNS) failure – **Go to question 6.**
- Gastrointestinal (GI) failure (*not liver*) – **Go to question 6.**
- Liver failure (not VOD) – **Go to question 6.**
- Multiple organ failure – **Go to question 5.**
- Pulmonary failure– **Go to question 6.**
- Renal failure – **Go to question 6.**
- Veno-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) – **Go to question 6.**
- Other organ failure – **Go to question 5.**

Pulmonary

- Acute respiratory distress syndrome (ARDS) (*other than IPS*) – **Go to question 6.**
- Diffuse alveolar damage (*without hemorrhage*) – **Go to question 6.**
- Idiopathic pneumonia syndrome (IPS) – **Go to question 6.**
- Pneumonitis due to Cytomegalovirus (CMV) – **Go to question 6.**
- Pneumonitis due to other virus – **Go to question 6.**
- Other pulmonary syndrome (*excluding pulmonary hemorrhage*) – **Go to question 5.**

Toxicity

- Neurotoxicity (ICANS) – **Go to question 6.**
- Tumor lysis syndrome – **Go to question 6**

Vascular

- Disseminated intravascular coagulation (DIC) – **Go to question 6.**
- Thromboembolism – **Go to question 6.**
- Thrombotic microangiopathy (TMA) (Thrombotic thrombocytopenic purpura (TTP)/Hemolytic Uremic Syndrome (HUS)) – **Go to question 6.**
- Other vascular - **Go to question 5.**

Other

- Accidental death – **Go to question 6.**
- Suicide – **Go to question 6.**
- Other cause - **Go to question 5.**

5. Specify: _____

Contributing Cause of Death

6. **Contributing cause of death** (*check all that apply*)

- Recurrence / persistence / progression of disease for which the **infusion** was performed – **Go to First Name**
 - Acute GVHD – **Go to First Name**
 - Chronic GVHD – **Go to First Name**
 - Graft rejection or failure – **Go to First Name**
 - Cytokine release syndrome – **Go to First Name**

Hemorrhage

- Diffuse alveolar hemorrhage (DAH) – **Go to First Name**
- Gastrointestinal hemorrhage – **Go to First Name**
- Hemorrhagic cystitis – **Go to First Name**
- Intracranial hemorrhage – **Go to First Name**
- Pulmonary hemorrhage – **Go to First Name**
- Other hemorrhage – **Go to question 7.**

Infection

- Bacterial infection – **Go to First Name**
- COVID-19 (SARS-CoV-2) – **Go to First Name**
- Fungal infection – **Go to First Name**
- Infection, organism not identified – **Go to First Name**
- Protozoal infection – **Go to First Name**
- Viral infection – **Go to First Name**
- Other infection – **Go to question 7.**

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- Renal failure – **Go to First Name**
- Venous-occlusive disease (VOD) / sinusoidal obstruction syndrome (SOS) – **Go to First Name**
- Other organ failure – **Go to question 7.**

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Other

- Accidental death – **Go to First Name**
- Suicide – **Go to First Name**
- Other cause - **Go to question 7.**

7. Specify: _____

First Name: _____

Last Name: _____

E-mail address: _____

Date: _____

YYYY MM DD