



Infectious Disease Markers

Registry Use Only

Sequence Number: _____

Date Received: _____

OMB No: 0915-0310

Expiration Date: 10/31/2022

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0310.

Public reporting burden for this collection of information is estimated to average 1 hour 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 hour 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 14N39, Rockville, Maryland, 20857.

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:**

Registry donor ID: _____

Non-NMDP cord blood unit ID: _____

GRID: _____

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 (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. FDA licensed NAAT testing for HBV
- 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. FDA licensed NAAT testing for HCV
- Positive →
- Negative →
- 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. FDA licensed NAAT testing for HIV-1

- Positive →
- Negative →
- 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 (person completing form): _____

Last Name: _____

E-mail address: _____

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