

Recipient NMDP ID: - -

Recipient Last Name:

What was the Primary Disease for which transplant was performed? **XDISPRIM**

Acute myelogenous leukemia (AML)

AMLTYPE

- 1 M1, myeloblastic
- 2 M2, myelocytic
- 3 M3, promyelocytic (APML, APL)
- 4 M4, myelomonocytic (AMML)
- 5 M5, monocytic (AMMOL)
- 6 M6, erythroblastic (AEL)
- 7 M7, megakaryoblastic
- 8 Granulocytic sarcoma
- 9 Other, specify _____
- 10 Unknown

Please Complete Form 120 – Insert I

Other leukemia

OTLTYPE

- 1 Acute undifferentiated leukemia
- 2 Biphenotypic, bilineage or hybrid leukemia
- 3 Acute mast cell leukemia
- 4 Chronic lymphocytic leukemia (CLL)
- 5 Hairy cell leukemia
- 6 Juvenile CML (no evidence of Philadelphia chromosome or BCR/ABL)
- 7 Prolymphocytic leukemia (PLL)
- 8 Other, specify _____
- 9 Unknown

Please Complete Form 120 – Insert IV

Acute lymphoblastic leukemia (ALL)

ALLTYPE

- 1 Mature B-cell (L3)
- 2 T-cell
- 3 Null cell (early pre-B)
- 4 cALLa (includes pre-B)
- 5 Other, specify _____
- 6 Unknown

Please Complete Form 120 – Insert II

MYETTYPE
 Myelodysplastic/ myeloproliferative disorders (Please classify all preleukemias)

(If recipient has transformed to AML, indicate AML as the primary disease)

- 1 Refractory anemia (RA)
- 2 Refractory anemia with excess blasts (RAEB)
- 3 Refractory anemia with excess blasts in transformation (RAEBT)
- 4 Chronic myelomonocytic leukemia (CMML)
- 5 Acquired idiopathic sideroblastic anemia (RARS)
- 6 Paroxysmal nocturnal hemoglobinuria (PNH)
- 7 Polycythemia vera
- 8 Essential or primary thrombocythemia
- 9 Myelofibrosis with myeloid metaplasia
- 10 Other myelofibrosis or myelosclerosis
- 11 Other myelodysplasia or myeloproliferative disorder, specify _____
- 12 Unknown

Please Complete Form 120 – Insert V

Chronic myelogenous leukemia

CMMLTYPE

- 1 Ph⁺; BCR/ABL+
- 2 Ph⁺; BCR/ABL-
- 3 Ph⁺; BCR/ABL unknown
- 4 Ph⁻; BCR/ABL+
- 5 Ph⁻; BCR/ABL-
- 6 Ph⁻; BCR/ABL unknown
- 7 Ph[?] unknown; BCR/ABL+
- 8 Ph[?] unknown; BCR/ABL-
- 9 Ph[?] unknown; BCR/ABL unknown

Please Complete Form 120 – Insert III

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Non-Hodgkin lymphoma

NHLTYPE

- 1 Small cell lymphocytic
 - 2 Follicular, predominantly small cleaved cell
 - 3 Follicular, mixed, small cleaved and large cell
 - 4 Follicular, predominantly large cell
 - 5 Diffuse, small cleaved cell
 - 6 Diffuse, mixed, small and large cell
 - 7 Diffuse, large cell
 - 8 Large cell, immunoblastic
 - 9 Lymphoblastic
 - 10 Small noncleaved cell, unclassified
 - 11 Small noncleaved cell, Burkitt
 - 12 Small noncleaved cell, non-Burkitt
 - 13 Mycosis fungoides
 - 14 Histiocytic
 - 15 Mantle zone/intermediate differentiation
 - 16 Composite
 - 17 Other NHL, specify _____
 - 18 NHL Unknown
- Please Complete Form 120 – Insert IX**

Hodgkin lymphoma

HODTYPE

- 1 Lymphocyte predominant
 - 2 Nodular sclerosis
 - 3 Mixed cellularity
 - 4 Lymphocyte depleted
 - 5 Other HD, specify _____
 - 6 HD Unknown
- Please Complete Form 120 – Insert IX**

Multiple myeloma/plasma cell disorder

MMYTYPE

- 1 Multiple myeloma
- Please Complete Form 120 – Insert VI**
- 2 Plasma cell leukemia
 - 3 Waldenstrom macroglobulinemia
 - 4 Other, specify _____
 - 5 Unknown
- Continue with Question 10 on page 5**

Other malignancies

OTMTYPE

- 1 Neuroblastoma
 - 2 Breast cancer
 - 3 Ewing sarcoma
 - 4 Small cell lung cancer
 - 5 Central nervous system tumors
 - 6 Other, specify _____
- Please Complete Form 120 – Insert VII**

Severe aplastic anemia

SAATYPE

- 1 Idiopathic
 - 2 Secondary to hepatitis
 - 3 Secondary to toxin/other drug
 - 4 Amegakaryocytosis (not congenital)
 - 5 Other, specify _____
 - 6 Unknown
- Please Complete Form 120 – Insert VIII**

Inherited abnormalities of erythrocyte differentiation or function (If recipient has developed leukemia, complete insert for appropriate leukemic diagnosis)

ERYTYPE

- 1 Fanconi anemia
 - 2 Diamond-Blackfan anemia (pure red cell aplasia)
- Please Complete Form 120 – Insert VIII**
- 3 Thalassemia major (β thalassemia)
 - 4 Sickle cell anemia
 - 5 Other hemoglobinopathy, specify _____
 - 6 Other, specify _____
- Continue with Question 10 on page 5**

Recipient NMDP ID: --

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Severe combined immunodeficiency (SCID) and other disorders primarily affecting the immune system

SCIDTYPE

- 1 Adenosine deaminase (ADA) deficiency – SCID
- 2 Absence of T and B cells – SCID
- 3 Absence of T, normal B cell – SCID
- 4 Omenn syndrome
- 5 Reticular dysgenesis
- 6 Bare lymphocyte syndrome
- 7 Other SCID, specify

Please Complete Form 120 – Insert X

- 8 Wiskott-Aldrich syndrome

Please Complete Form 120 – Insert XI

- 9 Ataxia telangiectasia
- 10 HIV infection
- 11 DiGeorge anomaly
- 12 Chronic granulomatous disease
- 13 Chediak-Higashi syndrome
- 14 Common variable immunodeficiency
- 15 X-linked lymphoproliferative syndrome
- 16 Leukocyte adhesion deficiency (Gp-180 deficiency, CD-18 deficiency, LFA deficiency, WBC adhesion deficiency)
- 17 Kostmann neutropenia
- 18 Neutrophil actin deficiency
- 19 Cartilage – hair hypoplasia
- 20 Combined immunodeficiency disease, specify
- 21 Other immunodeficiencies, specify

Continue with Question 10 on page 5

- 22 Immune system disorders unknown

PLATATYPE

Inherited abnormalities of platelets

- 1 Amegakaryocytosis/ congenital thrombocytopenia
- 2 Glanzmann thrombasthenia
- 3 Other, specify
- 4 Unknown inherited platelet disorder

Continue with Question 10 on page 5

Inherited disorders of metabolism

METTYPE

- 1 Osteopetrosis (malignant infantile osteopetrosis)
- 2 Lesch-Nyhan syndrome

Mucopolysaccharidoses

- 3 Hurler syndrome (IH)
- 4 Scheie syndrome (IS)
- 5 Hunter syndrome (II)
- 6 Sanfilippo (III)
- 7 Morquio (IV)
- 8 Maroteaux-Lamy (VI)
- 9 β -Glucuronidase deficiency (VII)
- 10 Mucopolysaccharidosis V
- 11 Other mucopolysaccharidosis, specify

Mucolipidoses

- 12 Gaucher disease
- 13 Metachromatic leukodystrophy
- 14 Adrenoleukodystrophy
- 15 Krabbe disease (globoid leukodystrophy)
- 16 Niemann-Pick disease
- 17 I-cell disease
- 18 Wolman disease
- 19 Glycogen storage disease
- 20 Lysosomal storage disease
- 21 Other mucolipidoses, specify

- 22 Unknown inherited metabolic disorder

Continue with Question 10 on page 5

HISTTYPE

Histiocytic disorders

- 1 Familial erythrophagocytic lymphohistiocytosis (FEL) (Familial hemophagocytic lymphohistiocytosis)
- 2 Histiocytosis-X
- 3 Hemophagocytosis
- 4 Other, specify

Continue with Question 10 on page 5

Other non-malignant disease

Specify _____

Continue with Question 10 on page 5

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COEXISTING

Were there clinically significant coexisting diseases (e.g., diabetes mellitus) or organ impairment within one month prior to conditioning?

- 1 yes
 2 no
- DXSIGHEM*
 - DXCORART*
 - DXHYPERT*
 - DXOTCARD*
 - DXDIAMEL*
 - DXTHYDIS*
 - DXOTENDO*
 - DXSEIZUR*
 - DXOTHCNS*
 - DXASTHMA*
 - DXPULMON*
 - DXGENITO*
 - DXGASTRO*
 - DXHEMATD*
 - DXFANCON*
 - DXDOWNSY*
 - DXOTCHRO*
 - DXOTMALI*
 - DXNEOGNH*
 - DXOTHER*

Indicate the diagnoses: *DX120X20*

17. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Significant hemorrhage (e.g., CNS or GI), specify site(s): _____
18. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Coronary artery disease
19. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Hypertension
20. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Other cardiac disease, specify: _____
21. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Diabetes mellitus
22. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Thyroid disease
23. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Other endocrine disease, specify: _____
24. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Seizure disorder
25. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Other CNS disease, specify: _____
26. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Asthma
27. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Pulmonary disease, specify: _____
28. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Genitourinary disease, specify: _____
29. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Gastrointestinal disease, specify: _____
30. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Hematologic disease, specify: _____
31. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Fanconi anemia
32. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Down syndrome
33. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Other chromosomal disorders, specify: _____
34. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	History of other malignancy, specify: _____
35. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Neonatal GVHD
36. 1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no	Other, specify: _____

Organ Function Prior To Conditioning

Provide values for recipient's liver function just prior to conditioning:

37. AST (SGOT)	<i>XSGOT</i>	<input type="text"/>	U/L	<i>SGOTAT</i>	38.	Month	Day	Year
40. ALT (SGPT)	<i>SGPT</i>	<input type="text"/>	U/L	<i>SGPTAT</i>	41.	<input type="text"/>	<input type="text"/>	<input type="text"/>
43. Total serum bilirubin	<i>XBILI</i>	<input type="text"/>	• <input type="text"/>	Unit of measurement: <i>BILIUM</i>	44.	<input type="text"/>	<input type="text"/>	<input type="text"/>
46. LDH	<i>LDH</i>	<input type="text"/>	U/L	<i>LDHAT</i>	47.	<input type="text"/>	<input type="text"/>	<input type="text"/>

What is the upper limit of normal for your institution?

39.	<input type="text"/>	U/L	<i>XSGOTULN</i>
42.	<input type="text"/>	U/L	<i>SGPTULN</i>
45.	<input type="text"/>	• <input type="text"/>	Unit of measurement: <i>BILIUM</i>
48.	<input type="text"/>	U/L	<i>LDHULN</i>

49. Did the recipient have known clinical liver disease (e.g., hepatitis) at any time prior to conditioning? *LIVERDIS*

1 yes
 2 no

50. Specify: _____

51. Date of onset: / / *LIVDISDT*

52. What was the recipient's serum creatinine prior to conditioning?

• Unit of measurement: *CRUM*

1 mg/dL 2 µmol/L

53. Date tested: / / *CRBT*

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1 yes
 2 no

a clinically important infection(s) present or being treated within one week prior to conditioning? **INF TREAT**

55. Select site and organism from lists shown below and place number in the appropriate spaces. If more than one site or organism was involved, list one site of infection and organism on the first line, second site and/or organism on second line.

	Site	Organism
BACIWK 1 <input type="checkbox"/> Bacterial XBACIT1 First	<input type="text"/>	Specific bacteria need not be identified
XBACIT2 Second	<input type="text"/>	
FNGIWK 2 <input type="checkbox"/> Fungal XFNGSIT1 First	<input type="text"/>	F <input type="text"/>
XFNGSIT2 Second	<input type="text"/>	F <input type="text"/>
VIRIWK 3 <input type="checkbox"/> Viral XVIRSI1 First	<input type="text"/>	V <input type="text"/>
XVIRSI2 Second	<input type="text"/>	V <input type="text"/>
PROIWK 4 <input type="checkbox"/> Protozoal/parasitic XPROSIT1 First	<input type="text"/>	P <input type="text"/>
XPROSIT2 Second	<input type="text"/>	P <input type="text"/>
OTHIWK 5 <input type="checkbox"/> Other organism OTHSTI1 First	<input type="text"/>	O <input type="text"/>
OTHSTI2 Second	<input type="text"/>	O <input type="text"/>

XFUNGSIT1 If other fungus, specify: **XFUNGSIT2**

XVIORSI1 If other virus, specify: **XVIORSI2**

XPROORSI1 If other protozoa, specify: **XPROORSI2**

XOTHORSI1 If other organism, specify: **XOTHORSI2**

Cont. with 56

Common Sites of Infection

01 Blood/buffy coat	24 Genito Urinary Tract
02 Disseminated - generalized, isolated at 3 or more distinct sites	25 Kidneys, renal pelvis, ureters and bladder
03 Central Nervous System	26 Prostate
04 Brain	27 Testes
05 Spinal cord	28 Fallopian tubes, uterus, cervix
06 Meninges and CSF	29 Vagina
07 Central nervous system unspecified	29 Genito-urinary tract unspecified
08 Gastrointestinal Tract	30 Skin
09 Lips	31 Genital area
10 Tongue, oral cavity and oro-pharynx	32 Cellulitis
11 Esophagus	33 Herpes zoster
12 Stomach	33 Rash, pustules or abscesses not typical of any of the above
13 Gallbladder and biliary tree (not Hepatitis), pancreas	34 Skin unspecified
14 Small intestine	35 Other
15 Large intestine	36 Central venous catheter, not otherwise specified
16 Feces/stool	37 Woundsite or catheter tip
17 Peritoneum	38 Eyes
18 Liver	39 Ears
19 Gastrointestinal tract unspecified	39 Joints
20 Respiratory Tract	40 Bone marrow
21 Upper airway and nasopharynx	41 Bone cortex (osteomyelitis)
22 Laryngitis/larynx	42 Muscle (excluding cardiac)
23 Lower respiratory tract (lung)	43 Cardiac (endocardium, myocardium, pericardium)
24 Pleural cavity, pleural fluid	44 Lymph nodes
25 Sinuses	45 Spleen
26 Respiratory tract unspecified	46 Other unspecified

Commonly Reported Organisms

1 Bacteria	
Specific bacteria will not be identified for pretransplant infections	
2 Fungal Infections	
F1 Candida albicans	F8 Aspergillus fumigatus
F2 Candida krusei	F9 Aspergillus niger
F3 Candida parapsilosis	F10 Aspergillus, not otherwise specified
F4 Candida tropicalis	F11 Cryptococcus species
F5 Torulopsis glabrata (a subspecies of candida)	F12 Fusarium species
F6 Candida, not otherwise specified	F13 Mucormycosis (Zygomycetes, Rhizopus)
F7 Aspergillus flavus	F14 Yeast, not otherwise specified
F15 Other fungus	
3 Viral Infections	
V1 Herpes simplex (HSV1, HSV2)	V12 Mumps
V2 Herpes zoster (chicken pox, varicella)	V13 Papovavirus
V3 Cytomegalovirus (CMV)	V14 Respiratory syncytial virus (RSV)
V4 Adenovirus	V15 Rubella (German measles)
V5 Enterovirus (coxsackie, echo, polio)	V16 Parainfluenza
V6 Hepatitis A (HAV)	V17 HHV-8 (Human virus herpes)
V7 Hepatitis B (HBV, Australian antigen)	V18 Epstein-Barr virus (EBV)
V8 Hepatitis C (includes non-A and non-B, HCV)	V19 Potyomavirus
V9 HIV-1, (HTLV-III)	V20 Rotavirus
V10 Influenza (flu)	V21 Rhinovirus (common cold)
V11 Measles (rubeola)	V22 Other viral
4 Protozoal/Parasitic Infections	
P1 Pneumocystis (PCP)	P5 Amoeba, (amebiasis)
P2 Toxoplasma	P6 Echinococcal cyst
P3 Giardia	P7 Trichomonas - either vaginal or gingivitis
P4 Cryptosporidium	P8 Other protozoal (parasite)
5 Other Infection	
O1 M. tuberculosis	O4 Mycoplasma
O2 Other mycobacterium	O5 Other organism
O3 Legionella	O6 No organism identified

56. Did the recipient have a history of clinically significant fungal infection at any time prior to conditioning for transplant? **FUNGEVER**

1 yes
 no

57. Please select organism from list above: **F** **FUNGSIG**

58. Date of onset: **FUNDT**

59. Select site(s) from list above: First **FUNSI1**
 Second **FUNSI2**

Cont. with 60

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Testing for serological evidence of prior viral exposure / infection

- | | | | | |
|---|-------------------------------------|-------------------------------------|---|---------------------------------------|
| 60. HTLV1 <i>HTLV1</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 61. Toxoplasma <i>TOXOPLAS</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 62. Cytomegalovirus antibody <i>CMV</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 63. Epstein-Barr antibody <i>EPSTBARA</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 64. Hepatitis B surface and/or core antibody <i>HEPBBDY</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 65. Hepatitis B surface antigen <i>HEPBGEN</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 66. Hepatitis C antibody <i>HEPCBODY</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 67. Hepatitis A antibody <i>HEPAGEN</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 68. HIV <i>5</i> <input type="checkbox"/> confidential <i>HIV</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |
| 69. Other, specify <i>OTHBODY</i> | 1 <input type="checkbox"/> positive | 2 <input type="checkbox"/> negative | 3 <input type="checkbox"/> inconclusive | 4 <input type="checkbox"/> not tested |

70. Was the recipient treated in an isolation room during the peri-transplant period? *ISORMYN*

- 1 yes
2 no

71. Please specify: *ISORMTYP*

- | | |
|--|--|
| 1 <input type="checkbox"/> Conventional private room | 4 <input type="checkbox"/> Positive pressure room |
| 2 <input type="checkbox"/> Laminar air flow room | 5 <input type="checkbox"/> HEPA filtered plus positive pressure room |
| 3 <input type="checkbox"/> HEPA filtered room | 6 <input type="checkbox"/> Other, specify: _____ |

Pretransplant Conditioning

72. Date pretransplant conditioning began: *PRETXCDT*

Month Day Year

73. Height at initiation of pretransplant conditioning (nearest centimeter without shoes): cm *PRETXCHT*

74. Weight at initiation of pretransplant conditioning (nearest kilogram without shoes): kg *PRETXCWT*

75. Was irradiation performed as part of the pretransplant preparative regimen? *PRETXRAD*

- 1 yes
2 no

Cont. with 111

76. Source of X-ray therapy: 1 Linear accelerator 2 ⁶⁰Co *XRAYSRCE*

77. Calculated dose-rate during irradiation: cGy (rad)/min *XRAYRATE*

78. What was the radiation field? *RADFIELDS*

- 1 Total body

79. Total dose: cGy *RFTOTDOS*

80. Starting date: *RFBT*

Month Day Year

81. Was radiation fractionated? *RFRACYN*

- 1 yes
2 no

82. Dose per fraction: cGy *RFDPF*

83. Number of days: *RFDAYS*

84. Total number of fractions: *RFRRACTS*

85. Was shielding used? *RFSHYN*

- 1 yes
2 no

86. Indicate which organs were shielded:

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| a. Lungs <i>RFSHLUNG</i> | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| b. Eyes <i>RFSHEYES</i> | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| c. Liver <i>RFSHLVR</i> | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| d. Kidney <i>RFSHKIDN</i> | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| e. Other, specify: <i>RFSHOTLR</i> | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Cont. with 105

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105. Was additional radiation given to other sites? *ADDXRT*

1 yes *→*
 2 no *CNSIRRAD*
GONIRRAD
SPLIRRAD
OTHIRRAD
RADDT

106. Was CNS irradiation performed? *CNSDOSE*
 1 yes 2 no Dose: cGy

107. Was gonadal irradiation performed? *GONDOSE*
 1 yes 2 no Dose: cGy

108. Was splenic irradiation performed? *SPLDOSE*
 1 yes 2 no Dose: cGy

109. Other site, specify: *OTHRDOSE*
 1 yes 2 no Dose: cGy

110. Date radiation started:
 Month Day Year

111. Were drugs given for pretransplant conditioning? *PTXDRGYN*

1 yes *→*
 2 no

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PTIDOX14

	Pre-Marrow Infusion	Date Started		
		Total Dose (in mg)	Month	Day
112. ALG, ALS, ATG, ATS ¹ <i>ALGDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
113. Busulfan (Myleran) ² <i>BUSULDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
114. Methylprednisilone ³ <i>METHYDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<i>METHANTH</i>				
1 <input type="checkbox"/> oral 2 <input type="checkbox"/> IV 3 <input type="checkbox"/> both				
115. Prednisone ⁴ <i>PREDNDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
116. Other corticosteroid ⁵ <i>OTCORDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
specify: _____				
117. Cyclophosphamide ⁶ <i>CASDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
118. Cytarabine (Ara-C) ⁷	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
119. Etoposide (VP-16) ⁸ <i>VALDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
120. Melphalan (L-Pam) ⁹ <i>MELPHDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<i>MELPHDT</i>				
1 <input type="checkbox"/> oral 2 <input type="checkbox"/> IV 3 <input type="checkbox"/> both				
121. Thiotepa ¹⁰ <i>THIOTDS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
122. Intrathecal methotrexate ¹¹ <i>INMTXDS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
123. Nitrosourea ¹² <i>NITRODOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
124. Monoclonal antibody ¹³ <i>MONOCDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
specify: _____				
125. Other ¹⁴ <i>OTHRDOS</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no				
specify: _____				

Recipient NMDP ID: - -

Recipient Last Name:

Compatibility Tests

For each of the following tests indicate whether it was a basis for matching the donor to the recipient:

- | | | | | |
|---|---------|------------------------------------|---------------------------------------|-------------------------------------|
| 126. Class I HLA Serology | CLSIHLA | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 127. Mixed Lymphocyte Culture (MLC) | MLC | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 128. Restriction Fragment Length Polymorphism (RFLP) | RFLP | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 129. Isoelectric Focusing (IEF) | IEF | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 130. Cytotoxic Lymphocyte Precursors (CTLP) | CTLP | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 131. Helper T Lymphocyte Precursors (HTLP) | HTLP | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 132. Class I Sequence Specific Oligo Probe (Class I SSOP) | SSOPI | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 133. Class II Sequence Specific Oligo Probe (Class II SSOP) | SSOPII | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |
| 134. Other, specify: _____ | | 1 <input type="checkbox"/> matched | 2 <input type="checkbox"/> mismatched | 3 <input type="checkbox"/> not done |

Transplant Maneuver

Questions 135-158 are for marrow only. For peripheral blood stem cells, continue with question 159 and complete Form 580. For cord blood, continue with question 159 and complete Form 680.

135. Copy donor reference number from specimen here: - - DONREFNO

136. Date of receipt of marrow at your facility: / / MARRECDT

137. Time (24-hour clock) at receipt of marrow: : 1 standard time MARRECDZ 2 daylight savings time

138. Storage temperature during transport: STORETEMP 1 Refrigerated at 1-8°C 2 Room temperature

139. Nucleated cell count of the marrow before processing (uncorrected cell count): NCCBEFB1 Bag one: • x 10⁶/ml Bag two: • x 10⁶/ml NCCBEFB2 NCCBEFB3 Bag three: • x 10⁶/ml Bag four: • x 10⁶/ml NCCBEFB4

140. Method used to determine nucleated cell count: NCCMETH 1 Coulter counter 2 Manual count 3 Other, specify: _____

141. Total volume of marrow before processing: • ml. VOLBEFOR

142. Was the marrow manipulated at your facility prior to transplant? 1 yes MANIPYN 2 no

Cont. with 150

143. Was the marrow manipulated for volume reduction only? 1 yes 2 no MANVRONL

144. Was the marrow plasma depleted only? 1 yes 2 no MANPLAS

145. Was the marrow manipulated for ABO incompatibility only? 1 yes 2 no MANABO

146. Was the marrow manipulated for GVHD prophylaxis? 1 yes 2 no MANGVHD

Cont. with 150

147. Specify method used: MANMETH
- 1 Antibody + complement
 - 2 Antibody + toxin
 - 3 Antibody affinity column
 - 4 Soybean lectin only
 - 5 Sheep red blood cell rosetting only
 - 6 Soybean lectin and sheep red blood cell rosetting
 - 7 Elutriation
 - 8 Immunomagnetic beads
 - 9 Antibody coated plates
 - 10 Soybean lectin and antibody coated plates
 - 11 Other, specify: _____

Recipient NMDP ID: - -

Recipient Last Name:

148. If antibodies were used during marrow manipulation, indicate which antibodies were used:

a. anti CD2 **ANTICD2** 1 yes 2 no
 b. anti CD3 **3** 1 yes 2 no
 c. anti CD4 **4** 1 yes 2 no
 d. anti CD5 **5** 1 yes 2 no
 e. anti CD6 **6** 1 yes 2 no
 f. anti CD7 **7** 1 yes 2 no
 g. anti CD8 **8** 1 yes 2 no
 h. anti CD34 **34** 1 yes 2 no
 i. Other **99** 1 yes 2 no specify: _____
 j. No antibodies used **ANTINONE**

149. What assays were performed to determine the number of T-cells left in the marrow after processing?

a. Flow cytometry 1 yes 2 no **FLCYTASY**
 b. Limiting dilution assay 1 yes 2 no **LDAASY**
 c. Other **OTHERASY** 1 yes 2 no specify: _____
 d. Not done **NOASSAYS**

150. Time (24-hour clock) at start of infusion: **TX TIME** : 1 standard time 2 daylight savings time **TX ZONE**

151. Total volume of marrow infused on the day of transplant: • ml. **VOLINFUS**

152. Cell count of infused marrow (uncorrected cell count): • x 10⁶/ml **NUCCINF**

153. Method used to determine cell count: 1 Coulter counter 2 Manual count 3 Other, specify: **CLCTMETH**

154. Was a fraction of the collected marrow cryopreserved for back-up infusion?
 1 yes → **CRYOYN**
 2 no

155. Total volume of cryopreserved marrow: • ml. **CRYOVOL**

156. Nucleated cell count of cryopreserved marrow: • x 10⁶/ml **CRYONCC**

157. Was there any adverse reaction associated with the infusion?
 1 yes → **ADVERSE I**
 2 no

158. Specify: _____

Recipient NMDP ID: --

Recipient Last Name:

1. Was this the first transplant for this recipient?

- yes
- no

FIRST TX

160. What was (were) the prior stem cell source(s)?

a. Autologous **AUTOLOG**

- 1 yes
- 2 no

161. a. Bone marrow AUTBM	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
b. Peripheral blood AUTPB	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

b. Allogeneic, unrelated **ALLOGUNR**

- 1 yes
- 2 no

162. a. Bone marrow ALUBM	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
b. Peripheral blood ALUPB	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
c. Cord blood ALUCB	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

c. Allogeneic, related

- 1 yes
- 2 no

ALLOGREL

163. a. Bone marrow	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
b. Peripheral blood	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no
c. Cord blood	1 <input type="checkbox"/> yes	2 <input type="checkbox"/> no

164. Date of the last transplant (transplant just before current transplant):

PRIORDT

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year			

165. Reason for *current* transplant:

- 1 No engraftment
- 2 Partial engraftment
- 3 Graft failure/rejection
- 4 Persistent malignancy
- 5 Recurrent malignancy
- 6 Other, specify: _____

REASON TX

166. Source of stem cells for current transplant: **CELLSRCE**

- 1 Autologous
 - 1 Cryopreserved bone marrow
 - 2 Cryopreserved peripheral blood stem cells **CELLSCTP**
- 2 Allogeneic, unrelated
 - 1 Fresh, original donor bone marrow
 - 2 Cryopreserved original donor bone marrow
 - 3 Fresh, second donor bone marrow
 - 4 Fresh, original donor mobilized peripheral blood stem cells
 - 5 Cryopreserved original donor mobilized peripheral blood stem cells
 - 6 Fresh, second donor mobilized peripheral blood stem cells
 - 7 NMDP cord blood
 - 8 Non-NMDP cord blood
- 3 Allogeneic, related
 - 1 Bone marrow
 - 2 Peripheral blood
 - 3 Cord blood

167. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____