

CLL TRIAL FOLLOW-UP FORM

IDENTIFICATION	IDENTIFICATION	FOLLOW-UP
Identification (UIC) <input style="width: 100px; height: 20px;" type="text"/> To which studygroup does the patient belong? <input type="checkbox"/> MRC <input type="checkbox"/> EBMT <input type="checkbox"/> French <input type="checkbox"/> Germany <input type="checkbox"/> Switzerland Result of Randomisation <input type="checkbox"/> No Transplant <input type="checkbox"/> Autotransplant	CTSU-Oxford issued randomisation number <input style="width: 40px; height: 20px;" type="text"/> Date of autotransplant <input style="width: 40px; height: 20px;" type="text"/> (as <input style="width: 40px; height: 20px;" type="text"/> /yyyy/mm/dd) Identification code of the patient within the hospital administration <input style="width: 100px; height: 20px;" type="text"/> Date of birth <input style="width: 40px; height: 20px;" type="text"/> (as <input style="width: 40px; height: 20px;" type="text"/> /yyyy/mm/dd) Sex of patient <input type="checkbox"/> male <input type="checkbox"/> female	SIC: DATE FOLLOW-UP <input style="width: 40px; height: 20px;" type="text"/> (as <input style="width: 40px; height: 20px;" type="text"/> /yyyy/mm/dd) Patient alive? <input type="checkbox"/> alive <input type="checkbox"/> dead

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Physical examination in CR? <input type="checkbox"/> no <input type="checkbox"/> yes Abnormalities found at physical examination <input type="checkbox"/> lymphadenopt <input type="checkbox"/> liver enlargement <input type="checkbox"/> splenomegaly <input type="checkbox"/> other <input type="checkbox"/> any combination of the above [if other, describe] <input style="width: 100px; height: 20px;" type="text"/> Performance Status>=2? <input type="checkbox"/> no (status = 0 or 1) <input type="checkbox"/> yes (status => 2) Lymphocytes (%) <input style="width: 30px; height: 20px;" type="text"/> Hemoglobin (g/dl) <input style="width: 30px; height: 20px;" type="text"/> Platelets (10**9/l) <input style="width: 30px; height: 20px;" type="text"/> Neutrophils (10**9/l) <input style="width: 30px; height: 20px;" type="text"/>	Blood chemistry <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> unknown or not performed - if abnormal describe <input style="width: 100px; height: 20px;" type="text"/> Immunophenotyping <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> unknown or not performed - if abnormal describe <input style="width: 100px; height: 20px;" type="text"/> Bone Marrow aspirate or biopsy (% lymphocytes) <input style="width: 30px; height: 20px;" type="text"/> ...or... <input type="checkbox"/> ??/not done Relapse/progression <input type="checkbox"/> no <input type="checkbox"/> yes - relapse Date: <input style="width: 40px; height: 20px;" type="text"/> (as <input style="width: 40px; height: 20px;" type="text"/> /yyyy/mm/dd)	Duration of therapy-requiring relapse <input style="width: 30px; height: 20px;" type="text"/> Date of therapy-requiring relapse <input style="width: 40px; height: 20px;" type="text"/> (as <input style="width: 40px; height: 20px;" type="text"/> /yyyy/mm/dd) Disease status <input type="checkbox"/> CR <input type="checkbox"/> VGPR <input type="checkbox"/> NPR <input type="checkbox"/> Other - if other, describe <input style="width: 100px; height: 20px;" type="text"/> 2nd malignancy <input type="checkbox"/> no <input type="checkbox"/> yes - if yes, describe <input style="width: 100px; height: 20px;" type="text"/> Richter Syndrome <input type="checkbox"/> no <input type="checkbox"/> yes Date of death <input style="width: 40px; height: 20px;" type="text"/> Cause of death describe <input style="width: 100px; height: 20px;" type="text"/>

RESIDUAL DISEASE STATUS - for CR only
Minimal Residual Disease investigated by: Immunophenotyping <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown Molecular Biology <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown Please indicate sensitivity of MRD assay: <input type="checkbox"/> Unknown

Please keep a copy and send form to:
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 2300 RC Leiden, The Netherlands

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