CIC: ..... Hospital UPN: ..... Patient UIC ..... HSCT Date: .....
*yyyy - mm - dd*

# HSCT - Minimum Essential Data - A

REGISTRATION - DAY 0

## Centre Identification

**EBMT Code** (CIC): ..... Contact person: .....

Hospital: ..... Unit: ..... Email: .....

## Patient Data

Date of this report: ..... First transplant for this patient?: ☐ Yes ☐ No
*yyyy - mm - dd*

Patient following national / international study / trial:

☐ No ☐ Yes: Name of study / trial ..... ☐ Unknown

**Hospital Unique Patient Number or Code (UPN)** .....

**Compulsory, registrations will not be accepted without this item.**

***All transplants performed in the same patient must be registered with the same patient identification number or code as this belongs to the patient and <u>not</u> to the transplant.***

Initials: ..... _ ..... (first name(s) _family name(s))

Date of birth: ..... Sex: ☐ Male ☐ Female
*yyyy - mm - dd* ***(at birth)***

## Primary Disease Diagnosis

Date of initial diagnosis: .....
*yyyy - mm - dd*

**PRIMARY DISEASE DIAGNOSIS** *(CHECK THE DISEASE FOR WHICH THIS TRANSPLANT WAS PERFORMED)*

| | | |
|---|---|---|
| ☐ Acute Leukaemia<br>☐ Acute Myelogenous Leukaemia (AML) related Precursor Neoplasms<br>☐ Precursor Lymphoid Neoplasms (old ALL)<br>☐ Therapy related myeloid neoplasms (old Secondary Acute Leukaemia)<br>☐ Chronic Leukaemia<br>☐ Chronic Myeloid Leukaemia (CML)<br>☐ Chronic Lymphocytic Leukaemia (CLL)<br>☐ Lymphoma<br>☐ Non Hodgkin<br>☐ Hodgkin's Disease | ☐ Myeloma/Plasma cell disorder<br>☐ Solid Tumour<br>☐ Myelodysplastic syndromes / Myeloproliferative neoplasm<br>☐ MDS<br>☐ MDS/MPN<br>☐ Myeloproliferative neoplasm<br>☐ Bone marrow failure including Aplastic anaemia<br>☐ Inherited disorders<br>☐ Primary immune deficiencies<br>☐ Metabolic disorders | ☐ Histiocytic disorders<br>☐ Autoimmune disease<br>☐ Juvenile Idiopathic Arthritis<br>☐ Multiple Sclerosis<br>☐ Systemic Lupus<br>☐ Systemic Sclerosis<br>☐ Haemoglobinopathy |

☐ Other diagnosis, specify: _____

# MYELOPROLIFERATIVE NEOPLASMS (MPN) (main disease code 6)

## Disease

**Date of Initial Diagnosis:** ----------
*yyyy - mm - dd*

- ☐ Primary myelofibrosis *(Chronic idiopathic myelofibrosis; fibrosis with myeloid metaplasia)*
- ☐ Polycythaemia vera
- ☐ Essential or primary thrombocythaemia
- ☐ Hyper eosinophilic syndrome (HES)
- ☐ Chronic eosinophilic leukaemia (CEL)
- ☐ Chronic neutrophilic leukaemia
- ☐ Systemic mastocytosis
- ☐ Mast cell leukaemia
- ☐ Mast cell sarcoma
- ☐ MPN not otherwise specified
- ☐ Other, specify:_____

- ☐ Myeloid and lymphoid neoplasms with FGFR1 abnormalities *(Stem cell leukaemia-lymphoma syndrome, 8p11 syndrome)*

## Secondary Origin?

**Secondary origin:**

- ☐ Yes : Disease related to prior exposure to therapeutic drugs or radiation
- ☐ No
- ☐ Unknown

## Risk Score

**IPSS Risk score for Myelofibrosis**

☐ Low risk ☐ Intermediate-1 ☐ Intermediate-2 ☐ High risk ☐ Not Evaluated ☐ Unknown

CIC: ..... Hospital UPN: ..... Patient UIC ..... HSCT Date: .....
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# MYELOPROLIFERATIVE NEOPLASMS (MPN) (main disease code 6)

## Chromosome Analysis at Diagnosis

**Chromosome analysis at diagnosis**

☐ Not done or failed ☐ Done: Normal ☐ Done: Abnormal ☐ Unknown

If abnormal:

Complex kariotype: ☐ No ☐ Yes ☐ Unknown
(3 or more abnormalities)

You can transcribe the complete karyotype: .....
OR

Indicate below those abnormalities that have been **evaluated** and whether they were **Absent** or **Present**

| | |
|---|---|
| Abn 1, specify ..... | ☐ Absent ☐ Present ☐ Not evaluated |
| Abn 5, specify ..... | ☐ Absent ☐ Present ☐ Not evaluated |
| Abn 7, specify ..... | ☐ Absent ☐ Present ☐ Not evaluated |
| trisomy 8 | ☐ Absent ☐ Present ☐ Not evaluated |
| trisomy 9 | ☐ Absent ☐ Present ☐ Not evaluated |
| Del 20 | ☐ Absent ☐ Present ☐ Not evaluated |
| Del 13 | ☐ Absent ☐ Present ☐ Not evaluated |
| Other, specify ..... | ☐ Absent ☐ Present ☐ Not evaluated |

## Molecular Markers at Diagnosis

☐ Not evaluated ☐ Evaluated: Absent ☐ Evaluated: Present ☐ Unknown

Indicate below those markers that have been **evaluated** and whether they were **Absent** or **Present**

| | | |
|---|---|---|
| BCR-ABL | ☐ Absent ☐ Present ☐ Not evaluated | |
| JAK2 mutation | ☐ Absent ☐ Present ☐ Not evaluated | If present: Allele burden % ..... |
| cMPL mutation | ☐ Absent ☐ Present ☐ Not evaluated | |
| Cal Reticulin mutation | ☐ Absent ☐ Present ☐ Not evaluated | |
| FIP1L1-PDGFR | ☐ Absent ☐ Present ☐ Not evaluated | |
| Other, specify ..... | ☐ Absent ☐ Present ☐ Not evaluated | |

# MYELOPROLIFERATIVE NEOPLASMS (MPN) (main disease code 6)

## Status at HSCT

**Date of this HSCT:** ----------
*yyyy - mm - dd*

***WHO Classification at HSCT:***

- ☐ Primary myelofibrosis *(Chronic idiopathic myelofibrosis; fibrosis with myeloid metaplasia)*
- ☐ Polycythaemia vera
- ☐ Essential or primary thrombocythaemia
- ☐ Hyper eosinophilic syndrome (HES)
- ☐ Chronic eosinophilic leukaemia (CEL)
- ☐ Chronic neutrophilic leukaemia
- ☐ Systemic mastocytosis
- ☐ Mast cell leukaemia
- ☐ Mast cell sarcoma

- ☐ Myeloid and lymphoid neoplasms with FGFR1 abnormalities *(Stem cell leukaemia-lymphoma syndrome, 8p11 syndrome)*
- ☐ Transformed to myelofibrosis from PV/ET: Date of transformation ----------
- ☐ Transformed to AML: Date of transformation ----------
*yyyy - mm - dd*

## Risk Score

**DIPSS Risk score for Myelofibrosis**

☐ Low risk ☐ Intermediate-1 ☐ Intermediate-2 ☐ High risk ☐ Not Evaluated

| **STATUS** | **NUMBER** |
|---|---|
| Treated with chemotherapy:<br>☐ Primary refractory phase (no change) | |
| ☐ Complete remission (CR) | ☐ 1st<br>☐ 2nd<br>☐ 3rd or higher |
| ☐ Improvement but no CR | |
| ☐ Relapse (after CR) | ☐ 1st<br>☐ 2nd<br>☐ 3rd or higher |
| ☐ Progression/worse<br>☐ Never treated (Supportive care or treatment without chemotherapy) | |

CIC: ..... Hospital UPN: ..... Patient UIC ..... HSCT Date: .....
*yyyy - mm - dd*

# HSCT

**Performance score** system used ☐ Karnofsky ☐ Lansky

Score ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ 100

**Weight (kg):** ..... **Height (cm):** .....

# Comorbidity Index

Sorror et al., Blood, 2005 Oct 15; 106(8): 2912-2919: *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1895304/*

Was there any ***clinically significant*** co-existing disease or organ impairment at time of patient assessment just prior to the preparative regimen?

☐ No ☐ Yes

| Comorbidity | Definitions | No | Yes | N/E |
|---|---|---|---|---|
| Solid tumour, previously present | Treated at any time point in the patient's past history, excluding non-melanoma skin cancer<br>Indicate type ..... | ☐ | ☐ | ☐ |
| Infammatory bowel disease | Crohn's disease or ulcerative colitis | ☐ | ☐ | ☐ |
| Rheumatologic | SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica | ☐ | ☐ | ☐ |
| Infection | Requiring continuation of antimicrobial treatment after day 0 | ☐ | ☐ | ☐ |
| Diabetes | Requiring treatment with insulin or oral hypoglycaemics but not diet alone | ☐ | ☐ | ☐ |
| Renal: moderate/severe | Serum creatinine > 2 mg/dL or >177 µmol/L, on dialysis, or prior renal transplantation | ☐ | ☐ | ☐ |
| Hepatic: mild | Chronic hepatitis, bilirubin between Upper Limit Normal (ULN) and 1.5 x the ULN, or AST/ALT between ULN and 2.5 × ULN | ☐ | ☐ | ☐ |
| moderate/ severe | Liver cirrhosis, bilirubin greater than 1.5 × ULN, or AST/ALT greater than 2.5 × ULN | ☐ | ☐ | ☐ |
| Arrhythmia | Atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias | ☐ | ☐ | ☐ |
| Cardiac | Coronary artery disease, congestive heart failure, myocardial infarction, EF ≤ 50%, or shortening fraction in children (<28%) | ☐ | ☐ | ☐ |
| Cerebrovascular disease | Transient ischemic attack or cerebrovascular accident | ☐ | ☐ | ☐ |
| Heart valve disease | Except mitral valve prolapse | ☐ | ☐ | ☐ |
| Pulmonary: moderate | DLco and/or FEV1 66-80% or dyspnoea on slight activity | ☐ | ☐ | ☐ |
| severe | DLco and/or FEV1 ≤ 65% or dyspnoea at rest or requiring oxygen | ☐ | ☐ | ☐ |
| Obesity | Patients with a body mass index > 35 kg/m2 | ☐ | ☐ | ☐ |
| Peptic ulcer | Requiring treatment | ☐ | ☐ | ☐ |
| Psychiatric disturbance | Depression or anxiety requiring psychiatric consultation or treatment | ☐ | ☐ | ☐ |

Were there any other major clinical abnormalities prior to the preparative regimen? Specify.....

CIC: _____ Hospital UPN: _____ Patient UIC _____ HSCT Date: _____
*yyyy - mm - dd*

# Type of HSCT (Allogeneic)

☐ **Allogeneic**

Patient CMV status ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Multiple donors *(including multiple CB units)* ☐ No ☐ Yes: Number of donors _____

# Donor 1

**HLA MATCH TYPE** *(DONOR RELATION WITH PATIENT)*

☐ HLA - Identical sibling *(may include non-monozygotic twin)*
☐ Syngeneic *(monozygotic twin)*
☐ HLA - Matched other relative
☐ HLA - Mismatched relative: Degree of mismatch ☐ 1 HLA locus mismatch ☐ >=2 HLA loci mismatch

Donor ID given by the centre _____

**HLA** MISMATCHES BETWEEN DONOR AND PATIENT
*(Mismatched relatives only)*

**Complete number of mismatches inside each box**

| A | B | C | DRB1 | DQB1 | DPB1 | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Antigenic |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Allelic |

*0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated*

☐ Unrelated donor

ION code of the Donor Registry or CB Bank _____

BMDW code of the Donor Registry or CB Bank *(If ION code is unknown)* *(up to 4 characters)* _____

Name of Donor Registry/ CB Bank *(If any of the above codes is unknown)* _____

Donor centre name *(if applicable, optional)* _____

**Donor** ID given by the Donor Registry or the CB Bank listed above _____

**Patient** ID given by the Donor Registry or the CB Bank listed above _____

⇨ Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

**Donor information**

Date of birth _____ *yyyy - mm - dd* OR Age at time of donation *(if date of birth not provided)* _____ _____ *month(s)*

Donor Sex ***(at birth)*** ☐ Male ☐ Female

Donor CMV status ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

**Did this donor provide more than one stem cell product**

☐ No - *(please fill "Donor 1 – Product Number 1" on next page*
☐ Yes: Number of different stem cell products infused from this donor _____
*(If 2 products e.g. BM PB, please fill "Donor 1 – Product Number 1 AND 2" on next page)*

# Donor 1 - Product Number 1

If more than one stem cell product, this is the FIRST product infused from this donor

Source of Stem Cells for **this product** , select only **one**

☐ Bone marrow ☐ Peripheral blood

☐ Cord blood ☐ Other: ----------

Graft manipulation ex-vivo of this product including T-cell depletion
*other than for RBC removal or volume reduction*

☐ No

☐ Yes Negative: ☐ No ☐ Yes:

☐ *T-cell (CD3+) depletion (do not use for "Campath in bag")*
☐ T-cell receptor αβ depletion
☐ B-cell depletion (CD19+) by MoAB
☐ NK cell depletion by MoAB
☐ Other ----------

Positive: ☐ No ☐ Yes
☐ CD34+ enrichment

Genetic manipulation ☐ No ☐ Yes

⇨ Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

# Donor 1 - Product Number 2

If more than one stem cell product, this is the SECOND product infused from this donor

Source of Stem Cells for **this product** , select only **one**

☐ Bone marrow ☐ Peripheral blood

☐ Cord blood ☐ Other: ----------

Graft manipulation ex-vivo of this product including T-cell depletion
*other than for RBC removal or volume reduction*

☐ No

☐ Yes Negative: ☐ No ☐ Yes:

☐ *T-cell (CD3+) depletion (do not use for "Campath in bag")*
☐ T-cell receptor αβ depletion
☐ B-cell depletion (CD19+) by MoAB
☐ NK cell depletion by MoAB
☐ Other ----------

Positive: ☐ No ☐ Yes
☐ CD34+ enrichment

Genetic manipulation ☐ No ☐ Yes

⇨ Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

CIC: ..... Hospital UPN: ..... Patient UIC ..... HSCT Date: .....
*yyyy - mm - dd*

# Donor 2

**HLA MATCH TYPE** *(DONOR RELATION WITH PATIENT)*

- ☐ HLA - Identical sibling *(may include non-monozygotic twin)*
- ☐ Syngeneic *(monozygotic twin)*
- ☐ HLA - Matched other relative
- ☐ HLA - Mismatched relative Degree of mismatch ☐ 1 HLA locus mismatch ☐ >=2 HLA loci mismatch

.....

**HLA** MISMATCHES BETWEEN DONOR AND PATIENT
*(Mismatched relatives only)*

**Complete number of mismatches inside each box**

| A | B | C | DRB1 | DQB1 | DPB1 | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Antigenic |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Allelic |

*0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated*

☐ Unrelated donor

ION code of the Donor Registry or CB Bank .....

BMDW code of the Donor Registry or CB Bank *(If ION code is unknown)* *(up to 4 characters)* .....

Name of Donor Registry/ CB Bank *(If any of the above codes is unknown)* .....

Donor centre name *(if applicable, optional)* .....

**Donor** ID given by the Donor Registry or the CB Bank listed above .....

**Patient** ID given by the Donor Registry or the CB Bank listed above .....

⇨ **Please enter the LABORATORY RESULTS WITH HLA TYPING into the database**

## Donor information

Date of birth ..... *yyyy - mm - dd* OR Age at time of donation *(if date of birth not provided)* .....*year(s)* .....*month(s)*

Donor Sex *(at birth)* ☐ Male ☐ Female

Donor CMV status ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

**Did this donor provide more than one stem cell product**

- ☐ No *(please fill "Donor 1 – Product Number 1" on next page*
- ☐ Yes: Number of different stem cell products infused from this donor .....

*(If 2 products e.g. BM PB, please fill "Donor 1 – Product Number 1 AND 2" on next page)*

# Donor 2 - Product Number 1

If more than one stem cell product, this is the FIRST product infused from this donor

**Source of Stem Cells for this product, select only one**

☐ Bone marrow ☐ Peripheral blood

☐ Cord blood ☐ Other source _____

Graft manipulation ex-vivo including T-Cell depletion

*other than for RBC removal or volume reduction*

☐ No

☐ Yes Negative: ☐ No ☐ Yes:

- ☐ *T-cell (CD3+) depletion (do not use for "Campathbag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ Other _____

Positive: ☐ No ☐ Yes

- ☐ CD34+ enrichment

Genetic manipulation ☐ No ☐ Yes

⇨ Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

# Donor 2 - Product Number 2

If more than one stem cell product, this is the SECOND product infused from this donor

**Source of Stem Cells for this product, select only one**

☐ Bone marrow ☐ Peripheral blood

☐ Cord blood ☐ Other source _____

Graft manipulation ex-vivo including T-Cell depletion

*other than for RBC removal or volume reduction*

☐ No

☐ Yes Negative: ☐ No ☐ Yes:

- ☐ *T-cell (CD3+) depletion (do not use for "Campathbag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ Other _____

Positive: ☐ No ☐ Yes

- ☐ CD34+ enrichment

Genetic manipulation ☐ No ☐ Yes

⇨ Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

# HSCT (Continued)

Chronological number of HSCT for this patient? | |

If >1, date of last HSCT before this one _____
*yyyy - mm - dd*

If >1, type of last HSCT before this one ☐ Allo ☐ Auto

If >1 and Allograft, Was the same donor used for all prior and current HSCTs? ☐ No ☐ Yes

If >1, was last HSCT peformed at another institution? ☐ No ☐ Yes: CIC if known _____

Name of the institution _____

City _____

⇨ If >1, please submit an Annual follow up form before proceeding, **giving the date of the subsequent transplant as the date of last contact**
(This is so we can capture relapse data and other events between transplants).

**HSCT part of a planned multiple (sequential) graft protocol** *(program)**?***

☐ No ☐ Yes

# Preparative Regimen

**Preparative** (conditioning) **regimen given?**

☐ No *(Usually Paed Inherited Disorders only) Go to GvHD Prophylaxis*

☐ Yes

**Was this intended to be myeloablative?** *(allo only)*

☐ Yes ☐ No: Reason

☐ Age of recipient
☐ Comorbid conditions
☐ Prior HSCT
☐ Protocol driven
☐ Other, specify _____

**Drugs** ☐ No ☐ Yes ☐ Unknown

*(include any active agent be it chemo, monoclonal antibody, polyclonal antibody, serotherapy, etc.)*

**Specification and dose of the preparative regimen**

## TOTAL PRESCRIBED CUMULATIVE DOSE*

**as per protocol:**

| DRUG (given before day 0) | DOSE | UNITS | | |
|---|---|---|---|---|
| ☐ Ara-C (cytarabine) | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ ALG, ATG (ALS/ ATS)<br>Animal origin: ☐ Horse<br>☐ Rabbit<br>☐ Other, specify ..... | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Bleomycin | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Busulfan<br>☐ Oral ☐ IV ☐ Both | | ☐ mg/m2 | ☐ mg/kg | ☐ mg x hr/L<br>☐ micromol x min/L<br>☐ mg x min/mL |
| ☐ BCNU | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Bexxar (radio labelled MoAB) | | ☐ mCi | ☐ MBq | |
| ☐ CCNU | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Campath (AntiCD 52) | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Carboplatin | | ☐ mg/m2 | ☐ mg/kg | ☐ mg x hr/L<br>☐ micromol x min/L<br>☐ mg x min/mL |
| ☐ Cisplatin | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Clofarabine | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Corticosteroids | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Cyclophosphamide | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Daunorubicin | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Doxorubicin (adriamycine) | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Epirubicin | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Etoposide (VP16) | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Fludarabine | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Gemtuzumab | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Idarubicin | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Ifosfamide | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Imatinib mesylate | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Melphalan | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Mitoxantrone | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Paclitaxel | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Rituximab (mabthera, antiCD20) | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Teniposide | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Thiotepa | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Treosulphan | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Zevalin (radiolabelled MoAB) | | ☐ mCi | ☐ MBq | |
| ☐ Other radiolabelled MoAB<br>Specify ..... | | ☐ mCi | ☐ MBq | |
| ☐ Other MoAB, specify | | ☐ mg/m2 | ☐ mg/kg | |
| ☐ Other, specify ..... | | ☐ mg/m2 | ☐ mg/kg | |

**Report the total prescribed cumulative dose as per protocol. Multiply daily dose in mg/kg or mg/m² by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg*

**AUC = Area under the curve

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Total Body Irradiation (TBI) ☐ No ☐ Yes : Total prescribed radiation dose as per protocol ..... Gy

Number of fractions ..... over ..... radiation days

TLI, TNI, TAI ☐ No ☐ Yes : Total prescribed radiation dose as per protocol ..... Gy

*(lymphoid, nodal, abdominal)*

**GvHD prophylaxis or preventive treatment** *(Allografts only)*

☐ No ☐ Yes

If Yes: ☐ Drugs (Immunosuppressive chemo)

- ☐ ALG, ALS, ATG, ATS : *(given after day 0)* Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify .....
- ☐ Anti CD25*(MoAB in vivo)*
- ☐ Campath *(MoAB in vivo; can be "in the bag")*
- ☐ Systemic corticosteroids
- ☐ Cyclosporine
- ☐ Cyclophosphamide *(given after day 0)*
- ☐ Etanercept *(MoAB in vivo)*
- ☐ FK 506 *(Tacrolimus, Prograf)*
- ☐ Infliximab *(MoAB in vivo)*
- ☐ Methotrexate
- ☐ Mycophenolate *(MMF)*
- ☐ Sirolimus
- ☐ Other monoclonal antibody *(in vivo)* , specify .....
- ☐ Other agent (in vivo), specify.....
- ☐ Extracorporeal photopheresis (ECP)
- ☐ Other, specify .....

# Survival Status

**Survival Status on date of HSCT**

☐ Alive ☐ Dead

☐ Patient died between administration of the preparative regimen and date of HSCT

**Main Cause of Death** *(check only one main cause):*

- ☐ Relapse or Progression/Persistent disease
- ☐ HSCT Related Cause
- ☐ Unknown
- ☐ Other .....

**Contributory Cause of Death** *(check as many as appropriate):*

- ☐ GVHD
- ☐ Interstitial pneumonitis
- ☐ Pulmonary toxicity
- ☐ Infection:
  - ☐ bacterial
  - ☐ viral
  - ☐ fungal
  - ☐ parasitic
  - ☐ Unknown
- ☐ Rejection/Poor graft function
- ☐ History of severe Veno occlusive disorder (VOD)
- ☐ Haemorrhage
- ☐ Cardiac toxicity
- ☐ Central nervous system (CNS) toxicity
- ☐ Gastrointestinal (GI) toxicity
- ☐ Skin toxicity
- ☐ Renal failure
- ☐ Multiple organ failure
- ☐ Other, specify .....