CIC: Hospital Unique Patient Number (UPN): ..... HSCT Date..... .... - .... - ....
yyyy mm dd

DAY 0

MED-B GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) ....

Hospital ..... Unit .....

Contact person: .....

e-mail .....

Date of this report .... - .... - ....
yyyy mm dd

STUDY/TRIAL

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

PATIENT

Unique Identification Code (UIC) .... *(to be entered only if patient previously reported)*

Hospital Unique <u>Patient</u> 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) – surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

ABO Group ....

Rh factor: ☐ Absent ☐ Present ☐ Not evaluated

DISEASE

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

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

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

☐ Other diagnosis, specify:_____

DAY 0

MED-B
CHRONIC LYMPHOCYTIC LEUKAEMIA (AND OTHER LYMPHOCYTIC LEUKAEMIAS)

INITIAL DIAGNOSIS

Has the information requested in this section been submitted with a previous HSCT registration?

☐ Yes: go to "Pre-HSCT treatment" on page 4 ☐ No: proceed with this section

SUBCLASSIFICATION

☐ **Chronic Lymphocytic Leukaemia (CLL) / Small Lymphocytic Lymphoma (SLL)**

☐ **Prolymphocytic Leukaemia (PLL)**

- ☐ PLL, B-cell
- ☐ PLL, T-cell

OTHER:

☐ **Richter's syndrome:**

Transformed from a previously known CLL

☐ Yes: Date of original CLL diagnosis .... - .... - ....
yyyy mm dd

☐ No: Primary Richter *(without previous known diagnosis of CLL)*

☐ **Hairy Cell Leukaemia (HCL)**

☐ **Atypical Hairy Cell Leukaemia**

☐ **Other, specify** .....

CYTOGENETICS AT DIAGNOSIS (All methods including FISH)

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

Technique

☐ Conventional ☐ FISH ☐ Both ☐ Unknown

CLL and Richter			
Trisomy 12	☐ Absent	☐ Present	☐ Not evaluated
Del 13q14	☐ Absent	☐ Present	☐ Not evaluated
Del 11q22-23	☐ Absent	☐ Present	☐ Not evaluated
del(17p)	☐ Absent	☐ Present	☐ Not evaluated
PLL			
inv(14)(q11q32)	☐ Absent	☐ Present	☐ Not evaluated
t(14:14)(q11q32)	☐ Absent	☐ Present	☐ Not evaluated
del(14)(q12)	☐ Absent	☐ Present	☐ Not evaluated
t(11:14)(q23;q11)	☐ Absent	☐ Present	☐ Not evaluated
t(7:14)(q35:q32.1)	☐ Absent	☐ Present	☐ Not evaluated
t(X:14)(q35:q11)	☐ Absent	☐ Present	☐ Not evaluated
idic(8) (p11)	☐ Absent	☐ Present	☐ Not evaluated
Other, specify ..... CHRMABND	☐ Absent	☐ Present	☐ Not evaluated

VH gene status

☐ Not mutated
☐ Mutated
IF EVALUATED: **VH3-21status** ☐ Not used ☐ Used
☐ Not evaluated
☐ unknown

MOLECULAR MARKERS AT DIAGNOSIS

TP53 mutations ☐ Absent ☐ Present ☐ Not evaluated ☐ unknown

Other types of markers
☐ Absent
☐ Present: ☐ ZAP-70: Expression cut-off used: --------%
☐ Other, specify ……
☐ Not evaluated
☐ unknown

IMMUNOPHENOTYPING of T-cells at diagnosis
(T-CELL PLL ONLY)
NOTE: TdT *(Terminal deoxynucleotidyl transferase)* must be negative

CD4+	☐ No	☐ Yes	☐ Not evaluated
CD8+	☐ No	☐ Yes	☐ Not evaluated

CLINICAL STATUS AT DIAGNOSIS

Lymphocyte count (T-CELL PLL ONLY) …… 10^9 cells/L

Lymphocyte doubling time ☐ < 12 months ☐ > 12 months ☐ Unknown

Binet stage ☐ A ☐ B ☐ C ☐ Not evaluated

PRE-HSCT TREATMENT

If this registration pertains to a second or subsequent HSCT the therapy number should be counted since last reported HSCT.

TREATMENT PRE-HSCT (PRIMARY TREATMENT)?

☐ No *proceed to "Date of HSCT" on page 5*

☐ Yes:

Date started .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(COUNTED FROM DIAGNOSIS, OR LAST HSCT IF APPLICABLE)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, vaccination, etc.)

Number of cycles .....
Date ended .....
yyyy mm dd

Radiotherapy ☐ No ☐ Yes

Response:

☐ CR ☐ PR ☐ No change ☐ Progression ☐ Other : ..... ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No

☐ Yes:

Date started .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(COUNTED FROM DIAGNOSIS, OR LAST HSCT IF APPLICABLE)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, vaccination, etc.)

Number of cycles .....
Date ended .....
yyyy mm dd

Radiotherapy ☐ No ☐ Yes

Response:

☐ CR ☐ PR ☐ No change ☐ Progression ☐ Other : ..... ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No

☐ Yes:

Date started .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(COUNTED FROM DIAGNOSIS, OR LAST HSCT IF APPLICABLE)

Modality: Chemo/drug/agent ☐ No ☐ Yes: Regimen .....
(including MoAB, vaccination, etc.)

Number of cycles .....
Date ended .....
yyyy mm dd

Radiotherapy ☐ No ☐ Yes

Response:

☐ CR ☐ PR ☐ No change ☐ Progression ☐ Other : ..... ☐ Unknown

☐ Unknown

DISEASE STATUS AT HSCT

To be evaluated just before starting conditioning

DATE OF HSCT: ..... - ..... - .....
yyyy mm dd

Splenectomy ☐ No ☐ Yes, Date : .... - .... - ....
yyyy mm dd

DISEASE STATUS

- ☐ Never treated
- ☐ CR
- ☐ PR
- ☐ Stable disease /No response
- ☐ Untreated relapse
- ☐ Progression: ☐ Sensitive to last regimen
  ☐ Resistant to last regimen
- ☐ Unknown

MRD *(ONLY TO BE COMPLETED WHEN PATIENT IS IN HAEMATOLOGICAL CR OR PR)*

Minimal residual disease *(by FACS or PCR)* :
☐ Negative ☐ Positive ☐ Not evaluated

Sensitivity of minimal residual disease (MRD) assay: …… ☐ Unknown

Worst Binet stage up to and including this date ☐ A ☐ B ☐ C ☐ Not evaluated

CHROMOSOME ANALYSIS AT HSCT

CYTOGENETICS

☐ Not done or failed ☐ Normal ☐ Abnormal ☐ Unknown

Technique

☐ Conventional ☐ FISH ☐ Both ☐ Unknown

Abnormalities

CLL			
Trisomy 12	☐ Absent	☐ Present	☐ Not evaluated
Del 13q14	☐ Absent	☐ Present	☐ Not evaluated
Del 11q22-23	☐ Absent	☐ Present	☐ Not evaluated
del(17p)	☐ Absent	☐ Present	☐ Not evaluated
PLL			
inv(14)(q11q32)	☐ Absent	☐ Present	☐ Not evaluated
t(14:14)(q11q32)	☐ Absent	☐ Present	☐ Not evaluated
del(14)(q12)	☐ Absent	☐ Present	☐ Not evaluated
t(11:14)(q23;q11)	☐ Absent	☐ Present	☐ Not evaluated
t(7:14)(q35:q32.1)	☐ Absent	☐ Present	☐ Not evaluated
t(X:14)(q35:q11)	☐ Absent	☐ Present	☐ Not evaluated
idic(8) (p11)	☐ Absent	☐ Present	☐ Not evaluated
Other, specify ..... CHRMABND	☐ Absent	☐ Present	☐ Not evaluated

VH gene status

☐ Not mutated

☐ Mutated

IF EVALUATED: **VH3-21status** ☐ Not used ☐ Used

☐ Not evaluated

☐ unknown

HAEMATOLOGICAL VALUES

Hb (g/dL) .... ☐ Not evaluated

Platelets (10^9/L) .... ☐ Not evaluated

White Blood Cells (10^9/L) .... ☐ Not evaluated

% Lymphocytes .... ☐ Not evaluated

BM aspirate: % lymphocytes .... ☐ Not evaluated

BM trephine: % lymphocytes .... ☐ Not evaluated

CLINICAL DATA

Lymphadenopathy ☐ Yes ☐ No ☐ Not evaluated ☐ Unknown

If yes, number of lymph node sites ☐ <3 ☐ 3-5 ☐ >5 ☐ Not evaluated ☐ Unknown

Thoraco abdominal CT scan ☐ Normal ☐ Abnormal ☐ Not done ☐ Unknown

Palpable splenomegaly ☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

Physical examination *(if present)*: ..... cm (below costal margin) ☐ Not evaluated

Spleen span in ultrasound or CT scan: ..... cm (maximum diameter) ☐ Not evaluated

Palpable hepatomegaly ☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

Physical examination *(if present)*: ..... cm (below costal margin) ☐ Not evaluated

Liver span in ultrasound or CT scan: ..... cm (maximum diameter) ☐ Not evaluated

IF PATIENT HAS NOT BEEN TREATED BEFORE SKIP THIS SECTION AND GO THE TRANSPLANT SPECIFIC FORM

Purine analogue-refractory? ☐ No ☐ Yes ☐ Unknown
(non response or relapse within 6 months after completion of purine analogue- containing chemotherapy)

Early relapse after intensive therapy? ☐ No ☐ Yes ☐ Unknown
(within 24 months after completion of purine analogue-containing combination therapy or autologous SCT)

FORMS TO BE FILLED IN

TYPE OF HSCT

☐ AUTOgraft, **proceed to Autograft day 0 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 0 form**

If ☐ Other : ..... , contact the EBMT Central Registry Office for instructions

DAY 100

MED-B
CHRONIC LYMPHOCYTIC LEUKAEMIA (AND OTHER LYMPHOCYTIC LEUKAEMIAS)

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Date of this report .... - .... - ....
yyyy mm dd

Hospital Unique Patient Number .....

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

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of last HSCT for this patient: .... - .... - ....
yyyy mm dd

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

☐ CR ☐ PR ☐ No response ☐ Progression ☐ Unknown

DATE OF EVALUATION :..... ..... - .... - ....
yyyy mm dd

MRD *(ONLY TO BE COMPLETED WHEN PATIENT IS IN HAEMATOLOGICAL CR OR PR)*

Minimal residual disease *(by FACS or PCR)* :
☐ Negative ☐ Positive ☐ Not evaluated

Please indicate sensitivity of MRD assay: …… ☐ Unknown

HAEMATOLOGICAL VALUES

Hb (g/dL) .... ☐ Not evaluated
Platelets (10^9/L) .... ☐ Not evaluated
White Blood Cells (10^9/L) .... ☐ Not evaluated
% Lymphocytes .... ☐ Not evaluated

BM aspirate: % lymphocytes .... ☐ Not evaluated
BM trephine: % lymphocytes .... ☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

☐ AUTOgraft, **proceed to Autograft day 100 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 100 form**

FOLLOW UP	MED-B CHRONIC LYMPHOCYTIC LEUKAEMIA (AND OTHER LYMPHOCYTIC LEUKAEMIAS)

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Date of this report .... - .... - ....
yyyy mm dd

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

Hospital Unique Patient Number .....

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

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of the most recent transplant before this follow up: .... - .... - ....
yyyy mm dd

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH: .... - .... - ....
yyyy mm dd

Complications after Transplant (Allografts)

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

Maximum grade ☐ grade 0 *(Absent)* ☐ grade I ☐ grade II ☐ grade III ☐ grade IV ☐ Not evaluated

If present: ☐ New onset ☐ Recurrent ☐ Persistent

Reason: ☐ Tapering ☐ DLI ☐ Unexplained

Date onset of this episode: ....- .... - .... ☐ Not applicable
(if new or recurrent) *yyyy mm dd*

Stage:

Skin	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Liver	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Lower GI tract	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Upper GI tract	☐ 0 (none)	☐ I			
Other site affected	☐ No	☐ Yes			

Resolution

☐ No ☐ Yes: Date of resolution: ....- .... - ....
yyyy mm dd

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

CHRONIC GRAFT VERSUS HOST DISEASE (CGVHD)

Presence of cGvHD

☐ No

☐ Yes: ☐ First episode
☐ Recurrence

Date of onset .... - .... - ....
yyyy mm dd

☐ Present continuously since last reported episode

Maximum extent during this period
☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score during this period
☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

Organs affected ☐ Skin ☐ Gut ☐ Liver ☐ Mouth
☐ Eyes ☐ Lung ☐ Other, specify ..... ☐ Unknown

☐ Resolved: Date of resolution: .... - .... - ....
yyyy mm dd

LATE GRAFT FAILURE ☐ No ☐ Yes

OTHER COMPLICATIONS SINCE LAST REPORT

PLEASE USE THE DOCUMENT "DEFINITIONS OF INFECTIOUS DISEASES AND COMPLICATIONS AFTER STEM CELL TRANSPLANTATION" TO FILL THESE ITEMS.

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type	**Pathogen** *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	**Date** *Provide different dates for different episodes of the same complication if applicable.*
Bacteremia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		
ARDS		
Multiorgan failure due to infection		
ENDORGAN DISEASES		
Pneumonia		

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		
Retinitis		
Other:		
		yyyy mm dd

DOCUMENTED PATHOGENS *(Use this table for guidance on the pathogens of interest)*

Type	Pathogen	Type	Pathogen
Bacteria		Viruses	
	S. pneumoniae		HSV
	Other gram positive *(i.e.: other streptococci, staphylococci, listeria …)*		VZV
			EBV
	Haemophilus influenzae		CMV
	Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)*		HHV-6
			RSV
	Legionella sp		Other respiratory virus *(influenza, parainfluenza, rhinovirus)*
	Mycobacteria sp		
	Other:		Adenovirus
Fungi			HBV
	Candida sp		HCV
	Aspergillus sp		HIV
	Pneumocystis carinii		Papovavirus
	Other:		Parvovirus
Parasites			Other: .....
	Toxoplasma gondii		
	Other:		

NON INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type *(Check all that are applicable for this period)*	**Yes**	**No**	**Unknown**	**Date**
Idiopathic pneumonia syndrome	☐	☐	☐	
VOD	☐	☐	☐	
Cataract	☐	☐	☐	
Haemorrhagic cystitis, non infectious	☐	☐	☐	
ARDS, non infectious	☐	☐	☐	
Multiorgan failure, non infectious	☐	☐	☐	
HSCT-associated microangiopathy	☐	☐	☐	
Renal failure requiring dialysis	☐	☐	☐	
Haemolytic anaemia due to blood group	☐	☐	☐	
Aseptic bone necrosis	☐	☐	☐	
Other: .....…… VOTCOMPS	☐			

yyyy mm dd

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

Graft loss

☐ No ☐ Yes ☐ Not evaluated

Overall chimaerism ☐ Full *(donor ≥95 %)* ☐ Mixed *(partial)*
☐ Autologous reconstitution *(recipient ≥95 %)* ☐ Aplasia
☐ Not evaluated

INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS.
SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE.
COPY THIS TABLE AS MANY TIMES AS NECESSARY.

Date of test	Identification of donor or Cord Blood Unit given by the centre	Number in the infusion order *(if applicable)*	Cell type on which test was performed	% Donor cells	Test used
.... - ..... - .... *yyyy mm dd*	.....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

☐ Previously reported

☐ Yes, date of diagnosis: .... - .... - ....
yyyy mm dd

Diagnosis: ☐ AML ☐ MDS ☐ Lymphoproliferative disorder ☐ Other .....

IF THE PATIENT HAS RECEIVED AN ALLOGRAFT PRIOR TO THE DIAGNOSIS OF ACUTE LEUKAEMIA, ANSWER THE FOLLOWING QUESTION

Is this secondary malignancy a donor cell leukaemia**?** ☐ No ☐ Yes ☐ Not applicable

☐ No

ADDITIONAL DISEASE TREATMENT SINCE LAST FOLLOW UP (INCLUDES CELL THERAPY)

Was any additional treatment given for the disease indication for transplant

☐ No

☐ Yes: Start date of the additional treatment since last report: ....
yyyy mm dd

☐ Unknown

-Cell therapy

Did the disease treatment include additional cell infusions ***(excluding a new HSCT)***

☐ No

☐ Yes: Is this cell infusion an allogeneic boost? ☐ No ☐ Yes
An allo boost is an infusion of cells from the same donor without conditioning, with no evidence of graft rejection.

Is this cell infusion an autologous boost? ☐ No ☐ Yes

⇨ **If cell infusion is <u>not</u> a boost, please complete CELLULAR THERAPY on the following page**

CELLULAR THERAPY

One cell therapy regimen is defined as any number of infusions given within 10 weeks for the same indication. If more than one regimen of cell therapy has been given since last report, copy this section and complete it as many times as necessary.

Date of first infusion: ....
yyyy mm dd

Disease status before this cellular therapy ☐ CR ☐ Not in CR ☐ Not evaluated ☐ Unknown

Source of cells: ☐ Allo ☐ Auto
(check all that apply)

Type of cells *(check all that apply)*

☐ Donor lymphocyte infusion (DLI)

☐ Mesenchymal cells

☐ Fibroblasts

☐ Dendritic cells

☐ NK cells

☐ Regulatory T-cells

☐ Gamma/delta cells

☐ Other .....

☐ Unknown

Number of cells infused by type DLI only	
Nucleated cells (/kg*) *(DLI only)*	.... - .... x 10^8 ☐ Not evaluated ☐ unknown
CD 34+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
CD 3+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
Total number of cells infused any non DLI infusion	
All cells (cells/kg*) *(non DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown

Chronological number of this cell therapy for this patient .....

Indication *(check all that apply)*

☐ Planned/protocol
☐ Prophylactic
☐ Treatment of aGvHD
☐ Treatment viral infection
☐ Other, specify ....
☐ Treatment for disease
☐ Mixed chimaerism
☐ Treatment of cGvHD
☐ Loss/decreased chimaerism
☐ Treatment PTLD, EBV lymphoma

Number of infusions within 10 weeks .....
(count only infusions that are part of same regimen and given for the same indication)

Acute Graft Versus Host Disease *(after this infusion but before any further infusion / HSCT)*:

Maximum grade ☐ grade 0 (absent) ☐ grade 1 ☐ grade 2
☐ grade 3 ☐ grade 4 ☐ present, grade unknown

-Chemo / radiotherapy

Additional disease treatment given excluding cell infusion?

☐ No
☐ Yes: ☐ Preemptive / preventive *(planned before the transplant took place)*
☐ For relapse / progression or persistent disease *(not planned)*

Date started ..... - ..... - .....
yyyy mm dd

Chemo/drug
☐ No
☐ Yes: ☐ Imatinib mesylate (Gleevec, Glivec)
☐ Dasatinib (Sprycel)
☐ Nilotinib (Tasigna)
☐ Bortezomib (Velcade)
☐ Lenalidomide (Revlimid)
☐ Rituximab (Rituxan, mabthera)
☐ Velafermin (FGF)
☐ Kepivance (KGF, palifermin)
☐ Thalidomide
☐ Eculizumab (Soliris)
☐ Other drug/chemotherapy, specify ……. Intrathecal: ☐ No ☐ Yes

Radiotherapy ☐ No ☐ Yes ☐ Unknown

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

☐ Previously reported
☐ No
☐ Yes; date diagnosed: .... - .... - .....
yyyy mm dd

Method of detection		**Site**
Cinical/haematological relapse or progression	☐ No: Date assessed ..... - ..... - ..... *yyyy mm dd* DHEMREL	
VRELLEUK	☐ Yes: Date first seen ..... - ..... - ..... *yyyy mm dd*	☐ marrow VRELLEU2 ☐ blood ☐ extramedullary
	☐ Not evaluated	
MRD relapse or progression	☐ No: Date assessed ..... - ..... - ..... *yyyy mm dd*	
	☐ Yes: Date first seen ..... - ..... - ..... *yyyy mm dd*	☐ marrow ☐ blood ☐ extramedullary
	Sensitivity of MRD assay: …… ☐ Unknown	
	☐ Not evaluated	

☐ Continuous progression since HSCT
☐ Unknown

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Complete Remission
☐ Stable disease
☐ Relapse
☐ Progression

MRD *(ONLY TO BE COMPLETED WHEN PATIENT IS IN HAEMATOLOGICAL CR OR PR)*

Minimal residual disease *(by FACS or PCR)* :
☐ Negative ☐ Positive ☐ Not evaluated

Please indicate sensitivity of MRD assay: …… ☐ Unknown

PREGNANCY AFTER HSCT

Has patient or partner become pregnant after this HSCT?

- ☐ No
- ☐ Yes: Did the pregnancy result in a live birth? ☐ No ☐ Yes ☐ Unknown
- ☐ Unknown

SURVIVAL STATUS

- ☐ Alive
- ☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

SCORE ☐ 100 (Normal, NED) ☐ 90 (Normal activity) ☐ 80 (Normal with effort) ☐ 70 (Cares for self) ☐ 60 (Requires occasional assistance) ☐ 50 (Requires assistance) ☐ 40 (Disabled) ☐ 30 (Severely disabled) ☐ 20 (Very sick) ☐ 10 (Moribund) ☐ Not evaluated ☐ Unknown

MAIN CAUSE OF DEATH *(if dead)*

- ☐ Relapse or progression
- ☐ Secondary malignancy *(including lymphoproliferative disease)*
- ☐ Transplantation related cause
- ☐ Cell therapy (non HSCT) Related Cause *(if applicable)*
- ☐ Unknown
- ☐ Other: .....

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

(check as many as appropriate)	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
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 toxicity	☐	☐	☐
Gastro intestinal toxicity	☐	☐	☐
Skin toxicity	☐	☐	☐
Renal failure	☐	☐	☐
Multiple organ failure	☐	☐	☐
Other:	☐		

ADDITIONAL NOTES IF APPLICABLE

COMMENTS .....

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IDENTIFICATION & SIGNATURE

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