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

Patient Number in EBMT database (if known): ……

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)*

- ☐ Primary 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 SOLID TUMOURS

INITIAL DIAGNOSIS

SUBCLASSIFICATION

Classification:

- ☐ Bone sarcoma (excluding Ewing sarcoma/PNET)
- ☐ Breast
- ☐ Central nervous system tumours (include CNS PNET)
- ☐ Colorectal
- ☐ Ewing sarcoma (ES)/PNET, extra-skeletal
- ☐ Ewing sarcoma (ES)/PNET, skeletal
- ☐ Germ cell tumour, extragonadal only
- ☐ Head and neck
- ☐ Hepatobiliary
- ☐ Kidney cancer excluding Wilm's tumour
- ☐ Lung cancer, non-small cell
- ☐ Lung cancer, small cell
- ☐ Medulloblastoma
- ☐ Melanoma
- ☐ Neuroblastoma
- ☐ Ovarian (carcinoma)
- ☐ Pancreatic
- ☐ Prostate
- ☐ Renal cell
- ☐ Retinoblastoma
- ☐ Rhabdomyosarcoma
- ☐ Soft tissue sarcoma (excluding Rhabdo and extra-skeletal ES)
- ☐ Germ cell tumour, gonadal
- ☐ Thymoma
- ☐ Wilm's tumour

☐ Other, specify .....

Histological grading: ..... (1 to 4) ☐ Not evaluated ☐ Unknown

TNM classification

Type: ☐ Clinical ☐ Pathological

	0	1	2	3	4	X	Not evaluated	Unknown
Tumour	☐	☐	☐	☐	☐	☐	☐	☐
Nodes	☐	☐	☐	☐		☐	☐	☐
Metastases*	☐	☐				☐	☐	☐

*For metastases, 0 indicates "No metastasis", 1 indicates "Metastasis" and X indicates "Not evaluable"

Disease-specific staging	I	II	III	IV	Not evaluated	Unknown
	☐	☐	☐	☐	☐	☐

HISTOLOGICAL SUBCLASSIFICATION

Describe

.....

.....

BREAST CARCINOMA ONLY

☐ Inflammatory ☐ Non-inflammatory

RECEPTOR STATUS

Estrogen (ER): ☐ Negative ☐ Positive: Values .... ☐ Not evaluated ☐ Unknown
☐ Not evaluated ☐ Unknown

Progesterone (PgR): ☐ Negative ☐ Positive: Values .... ☐ Not evaluated ☐ Unknown
☐ Not evaluated ☐ Unknown

HER2/neu (c-erb-B2): ☐ Negative ☐ Positive: Defined by ☐ IHC 3+
☐ IHC 2+ and FISH +
☐ Unknown
☐ Not evaluated ☐ Unknown

HISTOLOGICAL SUBCLASSIFICATION

Axillary lymph nodes at surgery: N° positive / N° examined = ... / .... ☐ Not evaluated

Sentinel Node ☐ Negative ☐ Positive ☐ Not evaluated

	1	2	3	Not evaluated	Unknown
S.B.R. (Scarff-Bloom-Richardson)	☐	☐	☐	☐	☐

Carcinoma type *(tick only one)*
☐ Ductal carcinoma ☐ Lobular carcinoma

Proliferation index (activity by Ki67 or MiB1 immunostaining) (% of positive cells) .....

GERM CELL TUMOURS ONLY

Histological classification
☐ Seminoma ☐ Non-seminoma

Site of origin
☐ Gonadal
☐ Extragonadal: ☐ retroperitoneal ☐ mediastinal ☐ other sites (specify**) .....**

CYTOGENETICS

☐ Normal ☐ Abnormal ☐ Not done ☐ Unknown

If abnormal, transcribe the chromosomal aberrations (e.g. tri/monosomy) and/or other results as text:

.....

MOLECULAR MARKERS

☐ Absent: type of oncogenes studied.....

☐ Present: indicate results.....

☐ Not evaluated

☐ Unknown

TREATMENT GIVEN BEFORE THIS HSCT

Treatment refers to any non HSCT treatment given before the first HSCT if the HSCT being reported is the 1st HSCT for this patient. If you are reporting a subsequent HSCT, treatment refers to any non HSCT treatment given after the last HSCT reported.

Treatment given: ☐ No: Includes a) Patients who have no surgery and go on to have high dose chemotherapy followed immediately by HSCT, or sequential chemotherapy, as the 1st line treatment; or

b) Subsequent HSCT within a multiple/ sequential chemotherapy HSCT procedure

If No *proceed to Status of disease at HSCT on page 6*

☐ Yes: Includes surgery or any other treatment, including chemotherapy, given prior to the HSCT and which is not considered part of the preparative *(conditioning)* regimen

If this is a subsequent HSCT, and the information on 1st line treatment has already been reported, go to Treatment history before HSCT on page 5 Otherwise, continue below.

FIRST LINE TREATMENT

Date 1st line treatment started .... - ....
yyyy mm dd

Did the first-line treatment include HSCT? ☐ Yes: ☐ Upfront *(treatment started with a program including high dose chemotherapy followed by HSCT or high dose sequential chemotherapy; adjuvant excluded)*
☐ Adjuvant *(HSCT done in adjuvant-setting)*
☐ No

Modality

☐ Chemotherapy: ☐ Adjuvant Chemotherapy
☐ Neoadjuvant Chemotherapy

Drugs *(tick as many as applicable)*

☐ Anthracyclines
☐ Taxanes
☐ Platinum compounds
☐ Antimetabolites
☐ Cyclophosphamide or other alkylating agents
☐ Vinca alcaloids
☐ Etoposide
☐ Other (specify): .....

☐ Surgery

If breast cancer, type of surgery: ☐ Mastectomy
☐ Conservative

☐ Radiotherapy

☐ Other: .....

Status of disease after first line treatment (best response)

☐ Complete Remission ☐ Stable Disease
☐ Partial Remission ☐ Refractory Disease
☐ Not Evaluable

Criteria used for evaluation ☐ WHO criteria
☐ RECIST criteria

ADDITIONAL LINES OF TREATMENT BEFORE THIS HSCT FOR RELAPSED/REFRACTORY DISEASE

Treatment given: ☐ No
☐ Yes

TREATMENT HISTORY BEFORE HSCT

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

TREATMENT SUMMARY *(if there was no treatment before this HSCT, skip this section and go to Status of disease at HSCT on page 6*

Total number of lines before this HSCT: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >4 ☐ unknown

Modality used at least once

Chemotherapy	☐ No	☐ Yes	☐ Unknown
Surgery	☐ No	☐ Yes	☐ Unknown
Radiotherapy	☐ No	☐ Yes	☐ Unknown
Other	☐ No	☐ Yes	☐ Unknown

STATUS OF DISEASE AT HSCT

GERM CELL TUMOURS

Risk category at disease recurrence (or platinum refractoriness) following first line CT

☐ Very Low ☐ Low ☐ Intermediate ☐ High ☐ Very High ☐ Not evaluated

STATUS OF DISEASE AT HSCT

☐ Adjuvant
☐ Never treated (upfront)
☐ Primary refractory
☐ Complete remission (CR)
  ☐ Confirmed ☐ Unconfirmed (CRU*)
  ☐ Unknown
☐ 1st Partial remission (PR1)
☐ Relapse
  ☐ Local ☐ Metastatic
☐ Progressive disease (PD)

**CRU – complete remission with persistent scan abnormalities of unknown significance*

NUMBER
(complete only for CR or relapse)
☐ 1st
☐ 2nd
☐ 3rd or higher

SENSITIVITY TO CHEMOTHERAPY
(complete only for relapse)
☐ Sensitive (SR:>50% response)
☐ Resistant (RR:<50% response)
☐ Untreated

Organ(s) involved

☐ Nodes Below Diaphragm
☐ Nodes Above Diaphragm
☐ Bone marrow
☐ Bone
☐ CNS
☐ Lungs
☐ Mediastinum
☐ Heart
☐ Soft Tissue
☐ Skin
☐ Gastrointestinal tract
☐ Urogenital tract
☐ Liver
☐ Ovaries/Testes
☐ Other: .....

Primary site affected: ☐ Yes ☐ No

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
SOLID TUMOURS

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

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

BEST RESPONSE AT 100 DAYS AFTER HSCT

- ☐ Complete Remission
- ☐ Very Good Partial Remission
- ☐ Partial Remission (>50%)
- ☐ Not Evaluable
- ☐ Stable Disease
- ☐ Progressive Disease
- ☐ Minor Response (>25% and <50%)

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

FORMS TO BE FILLED IN

TYPE OF HSCT

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

FOLLOW UP

MED-B SOLID TUMOURS

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

OTHER COMPLICATIONS SINCE LAST REPORT

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

INFECTIOUS 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: ..... VOTINCOM		
		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
	Haemophilus influenzae		EBV
	Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)*		CMV
	Legionella sp		HHV-6
	Mycobacteria sp		RSV
	Other:		Other respiratory virus *(influenza, parainfluenza, rhinovirus)*
Fungi			Adenovirus
	Candida sp		HBV
	Aspergillus sp		HCV
	Pneumocystis carinii		HIV
	Other:		Papovavirus
Parasites			Parvovirus
	Toxoplasma gondii		Other: .....
	Other:		

NON INFECTIOUS 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

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

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 TREATMENT SINCE LAST FOLLOW UP INCLUDING 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**

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

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	
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	
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 GvHD
☐ Loss/decreased chimaerism
☐ Other, specify ....
☐ Treatment for disease
☐ Mixed chimaerism
☐ Treatment viral infection
☐ 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/agent ..... ☐ Unknown
(including MoAB, vaccination, etc.)
Radiotherapy ☐ No ☐ Yes ☐ Unknown

Other treatment ☐ No ☐ Yes, specify: ..... ☐ Unknown
☐ Unknown

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

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

Organs involved at relapse or progression

☐ Local
☐ Distant: ☐CNS ☐ bone marrow ☐ lung
☐ liver ☐ bone ☐ pleura
☐ nodes ☐ soft tissue ☐ other: .....

☐ Continuous progression since HSCT

☐ Unknown

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Complete Remission ☐ Stable disease ☐ Relapse ☐ Progression

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

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

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 *(check only one main cause)*

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

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

	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection	☐	☐	☐
bacterial	☐	☐	☐
viral	☐	☐	☐
fungal	☐	☐	☐
parasitic	☐	☐	☐
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 .....

.....

.....

IDENTIFICATION & SIGNATURE

.....

_____