CIC: ..... Hospital 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:_____

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

DAY 0

MED-B
MULTIPLE SCLEROSIS

Neurologist Name_____

Address_____

Fax_____Email_____

INITIAL DIAGNOSIS

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

☐ Yes: proceed to "Date of HSCT" on page 3 ☐ No: proceed with this section

DIAGNOSTIC CRITERIA

Did the patient meet the Poser criteria for clinically-definite Multiple Sclerosis?
(Two attacks and clinical evidence of two separate lesions OR Two attacks; clinical evidence of one lesion and paraclinical evidence of another, separate lesion)

☐ No ☐ Yes ☐ Unknown

Did the patient meet the criteria for laboratory-supported Multiple Sclerosis?

☐ No ☐ Yes ☐ Unknown

FIRST LINE THERAPIES

THERAPIES

☐ No – *Proceed to "Date of HSCT"* ***on page 3***

☐ Yes:

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

Drugs ☐ No ☐ Yes ☐ Unknown

IF YES, MARK APPROPRIATE BOX:

- ☐ Cyclophosphamide
- ☐ Mitoxantrone
- ☐ Anti-lymphocyte antibodies/globulins (ALG)
- ☐ Corticosteroids
  - ☐ Chronic low dose
  - ☐ Pulse high dose
- ☐ Azathioprine
- ☐ Cop-I
- ☐ α-interferon
- ☐ β-interferon

Total lymph node (TLI) irradiation ☐ No ☐ Yes ☐ Unknown

Local Craniospinal radiotherapy ☐ No ☐ Yes ☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

Other modality:

Lymphocytopheresis ☐ No ☐ Yes ☐ Unknown

Plasmapheresis ☐ No ☐ Yes ☐ Unknown

Other, specify:..... :.....

DATE OF HSCT

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

TRANSPLANT TYPE

☐ Allogeneic: *Proceed to* STATUS OF DISEASE AT HSCT *on page 4*

☐ Autologous: Mobilised ☐ No: *Proceed to* STATUS OF DISEASE AT HSCT *on page 4*

☐ Yes: Date of 1st aphaeresis/collection: .... - .... - ....
yyyy mm dd

STATUS OF DISEASE AT MOBILISATION

Evaluation should be performed less than 4 weeks prior to mobilisation for stem cell collection.

CLINICAL EVALUATION

Scripps neurological rating scale

Score: ..... ☐ Unknown ☐ Not evaluated

Kurtze functional systems

Overall score: ..... ☐ Unknown ☐ Not evaluated

Kurtze Expanded Disability Status Scale (EDSS)

.....-..... ☐ Unknown ☐ Not evaluated

Composite Scale

Score: .....-..... ☐ Unknown ☐ Not evaluated

MRI BRAIN SCAN DONE

☐ Not done prior to mobilisation

☐ Yes: Date of most recent MRI scan of brain: .... - .... - .... ☐ Date unknown
yyyy mm dd

Results

Gadolinium-enhancing lesions present ☐ Number..... ☐ None ☐ Not evaluated ☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

STATUS OF DISEASE AT HSCT

Evaluation should be performed less than 2 weeks prior to conditioning

DISEASE COURSE

Indicate the disease course between diagnosis and mobilisation/HSCT

- ☐ Progressive relapsing (malignant)
- ☐ Primary progressive
- ☐ Secondary progressive (may have had previous Relapsing/Remitting)
- ☐ Relapsing/Remitting
- ☐ Not evaluable, explain: _____

Did the patient progress during the 2-years prior to mobilisation/HSCT?

☐ No ☐ Yes, number of relapses/progressions..... ☐ Unknown

CLINICAL EVALUATION

Scripps neurological rating scale

Score: ..... ☐ Unknown ☐ Not evaluated

Kurtze functional systems

Overall score: ..... ☐ Unknown ☐ Not evaluated

Kurtze Expanded Disability Status Scale (EDSS)

.....-..... ☐ Unknown ☐ Not evaluated

Composite Scale

Score: .....-..... ☐ Unknown ☐ Not evaluated

MRI BRAIN SCAN DONE

☐ Not done prior to HSCT

☐ Yes: Date of most recent MRI scan of brain: .... - .... - .... ☐ Date unknown
yyyy mm dd

Results

Gadolinium-enhancing lesions present ☐ Number..... ☐ None ☐ Unknown

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

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

DAY 100

MED-B
MULTIPLE SCLEROSIS

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

STATUS AT 100 DAYS POST-HSCT

BEST DISEASE STATUS AT 100 DAYS AFTER TRANSPLANTATION

To be completed 100 days post transplant, or at time of death if death occurred <100 days post transplant.

☐ Response ☐ Transient *(remission followed by relapse / progression)* ☐ No response

☐ Relapse / progression ☐ Not evaluated

Date of evaluation ..... - ..... - .....
yyyy mm dd

CLINICAL EVALUATION

Scripps neurological rating scale

Score: ..... ☐ Unknown ☐ Not evaluated

Kurtze functional systems

Overall score: ..... ☐ Unknown ☐ Not evaluated

Kurtze Expanded Disability Status Scale (EDSS)

.....-..... ☐ Unknown ☐ Not evaluated

Composite Scale

Score: .....-..... ☐ Unknown ☐ Not evaluated

MRI BRAIN SCAN DONE

☐ Not done within 100 days from HSCT

☐ Yes: Date of most recent MRI scan of brain: .... - .... - .... ☐ Date unknown
yyyy mm dd

Results

Are new lesions present on the MRI?

☐ No

☐ Yes, Indicate new lesions present: ☐ Gadolinium-enhancing
(check only one) ☐ Unenhancing
☐ Both
☐ Unknown

☐ Unknown

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**

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

FOLLOW UP

MED-B
MULTIPLE SCLEROSIS

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

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

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.

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		

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

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

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
	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 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 MYELOPROLIFERATIVE 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**

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 *Proceed to 'First Evidence of Disease Worsening Since Last HSCT' below*
☐ Yes: ☐ Preemptive / preventive *(planned before the transplant took place)*
☐ For relapse / progression or persistent disease *(not planned)*

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

Drugs

☐ No ☐ Yes ☐ Unknown

If yes, mark appropriate box:

☐ Cyclophosphamide

☐ Mitoxantrone

☐ Anti-lymphocyte antibodies

☐ Corticosteroids
☐ Chronic low dose
☐ Pulse high dose

☐ Azathioprine

☐ Cop-I

☐ α-interferon

☐ β-interferon

Irradiation (radiotherapy):

Site

Total lymph node (TLI) ☐ No ☐ Yes ☐ Unknown

Craniospinal ☐ No ☐ Yes ☐ Unknown

Other modality:

Lymphocytopheresis ☐ No ☐ Yes ☐ Unknown

Plasmapheresis ☐ No ☐ Yes ☐ Unknown

Other, specify:.....

FIRST EVIDENCE OF DISEASE WORSENING SINCE LAST HSCT

EVIDENCE OF DISEASE ACTIVITY

☐ Previously reported
☐ No
☐ Yes; date first noted: .... - .... - ....
yyyy *mm* *dd*
☐ Continuous worsening since HSCT

Number of relapses/progressions since last HSCT..... ☐ Unknown

LAST DISEASE AND PATIENT STATUS

Only if evaluation has been performed <2 weeks prior to this follow up including death

CLINICAL EVALUATION

Scripps neurological rating scale

Score: ..... ☐ Unknown ☐ Not evaluated

Kurtze functional systems

Overall score: ..... ☐ Unknown ☐ Not evaluated

Kurtze Expanded Disability Status Scale (EDSS)

.....-..... ☐ Unknown ☐ Not evaluated

Composite Scale

Score: .....-..... ☐ Unknown ☐ Not evaluated

MRI BRAIN SCAN DONE

☐ Not done

☐ Yes: Date of most recent MRI scan of brain: .... - .... - .... ☐ Date unknown
yyyy *mm* *dd*

Results

Are new lesions present on the MRI?

☐ No

☐ Yes, Indicate new lesions present: ☐ Gadolinium-enhancing
(check only one) ☐ Unenhancing
☐ Both
☐ Unknown

☐ 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

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

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

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

.....