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
SYSTEMIC SCLEROSIS

Name of Referring Physician _____

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

MAIN DIAGNOSIS

Classification of cutaneous Systemic Sclerosis at diagnosis according to ACR criteria:

- ☐ Limited (cutaneous thickening distal to elbows or knees, but not proximal)
- ☐ Diffuse
- ☐ SSc sine scleroderma
- ☐ Mixed Connective Tissue Disease (MCTD)
- ☐ Other, specify:_____

LABORATORY VALUES

		Units		
Serum creatinine:	.....	(μmol/l)	☐ Not evaluated	☐ unknown
Creatinine clearance:	.....	(ml/min)	☐ Not evaluated	☐ unknown
Creatinine phosphokinase:	☐ Normal ☐ Elevated		☐ Not evaluated	☐ Unknown
Proteinuria: total urinary protein excretion _____		mg/24hrs	☐ Not evaluated	☐ Unknown

AUTOANTIBODIES

Were tests for autoantibodies done at diagnosis? ☐ No ☐ Yes ☐ Unknown

SPECIFY ANTIBODY:

Anti-DNA topoisomerase I (Scl-70):	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-centromere (ACA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-nuclear (ANA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Other, specify.....	☐ Negative	☐ Positive		

FIRST LINE THERAPIES

THERAPIES

☐ No *If allograft, proceed to "Date of HSCT" on page 3*

☐ Yes:

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

Drug treatment ☐ No

☐ Yes: Cyclophosphamide ☐ Yes: total cumulative dose ……Units …….

Cyclosporine ☐

Methotrexate ☐

Prednisone or equivalent ☐

Mycophenolate Mofetil ☐

Tacrolimus/FK506 ☐

D-penicillamine ☐

Prostanoids/Prostaglandin analogs ☐

Other ☐ _____

☐ unknown

Phototherapy ☐ No ☐ Yes ☐ unknown

Other ☐ No

☐ Yes, specify: .....

☐ unknown

DATE OF HSCT

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

HSCT TYPE

☐ Allogeneic: *Proceed to* STATUS OF DISEASE AT HSCT *on page 5*

☐ Autologous: Mobilised ☐ No: *Proceed to* STATUS OF DISEASE AT HSCT *on page 5*

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

STATUS OF DISEASE AT MOBILISATION

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

DISEASE STATUS

- ☐ Limited (cutaneous thickening distal to elbows or knees, but not proximal)
- ☐ Diffuse
- ☐ SSc sine scleroderma
- ☐ Other (MCTD: Mixed Connective Tissue Disease)
- ☐ other, specify:_____

SKIN THICKNESS

Modified Rodnan Skin Score (max 51). : ..... ☐ Not evaluated ☐ Unknown
(Appendix B. 10)

PERFORMANCE System used: ☐ Karnofsky ☐ Lansky

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

LABORATORY VALUES

		Units		
Serum creatinine:	.....	(μmol/l)	☐ Not evaluated	☐ unknown
Creatinine clearance:	.....	(ml/min)	☐ Not evaluated	☐ unknown
Creatinine phosphokinase:	☐ Normal ☐ Elevated		☐ Not evaluated	☐ Unknown
Proteinuria: total urinary protein excretion _____		mg/24hrs	☐ Not evaluated	☐ Unknown

AUTOANTIBODIES

Were tests for autoantibodies done at mobilisation? ☐ No ☐ Yes ☐ Unknown

SPECIFY ANTIBODY:

Anti-DNA topoisomerase I (Scl-70):	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-centromere (ACA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-nuclear (ANA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Other, specify.....	☐ Negative	☐ Positive		

PHYSICAL EXAMINATION RESULTS

Dyspnoea on exertion	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
DLCO ..... (% predicted)			☐ Not evaluated	☐ Unknown
Restrictive pulmonary function pattern	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Fibrosis on CXR	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Pulmonary artery hypertension (ECHO)	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Mean pulmonary arterial systolic pressure (PASP) .....mm/Hg			☐ Not evaluated	☐ Unknown

Systemic hypertension requiring treatment
- ☐ No
- ☐ Yes: ☐ With ACE Inhibitor
  ☐ With other, specify: .....
- ☐ Not evaluated
- ☐ Unknown

Arrhythmia / conduction blocks	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
GI involvement	☐ No	☐ Yes	☐ Not evaluated	

STATUS OF DISEASE AT HSCT

Evaluation should be performed <2 weeks prior to conditioning

DISEASE STATUS

- ☐ Limited (cutaneous thickening distal to elbows or knees, but not proximal)
- ☐ Diffuse
- ☐ SSc sine scleroderma
- ☐ Other (MCTD: Mixed Connective Tissue Disease)
- ☐ other, specify:_____

SKIN THICKNESS

Modified Rodnan Skin Score (max 51). : ..... ☐ Not evaluated ☐ Unknown
(Appendix B. 10)

LABORATORY VALUES

		Units		
Serum creatinine:	.....	(μmol/l)	☐ Not evaluated	☐ unknown
Creatinine clearance:	.....	(ml/min)	☐ Not evaluated	☐ unknown
Creatinine phosphokinase:	☐ Normal ☐ Elevated		☐ Not evaluated	☐ Unknown
Proteinuria: total urinary protein excretion _____		mg/24hrs	☐ Not evaluated	☐ Unknown

AUTOANTIBODIES

Were tests for autoantibodies done at conditioning? ☐ No ☐ Yes ☐ Unknown

SPECIFY ANTIBODY:

Anti-DNA topoisomerase I (Scl-70):	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-centromere (ACA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-nuclear (ANA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Other, specify.....	☐ Negative	☐ Positive		

PHYSICAL EXAMINATION RESULTS

Dyspnoea on exertion	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
DLCO ..... (% predicted)			☐ Not evaluated	☐ Unknown
Restrictive pulmonary function pattern	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Fibrosis on CXR	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Pulmonary artery hypertension (ECHO)	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Mean pulmonary arterial systolic pressure (PASP) .....mm/Hg			☐ Not evaluated	☐ Unknown

Systemic hypertension requiring treatment
- ☐ No
- ☐ Yes: ☐ With ACE Inhibitor
  ☐ With other, specify: .....
- ☐ Not evaluated
- ☐ Unknown

Arrhythmia / conduction blocks ☐ No ☐ Yes ☐ Not evaluated ☐ Unknown

INVOLVEMENT AND INDICATION FOR HSCT

Organ involvement *(check all that apply)*:	**YES**	*Check here if this involvement was the **Reason for HSCT***
GI tract	☐	☐
Heart	☐	☐
Lungs	☐	☐
Skin	☐	☐
Other, specify:_____	☐	☐

Severe functional impairment ☐ No ☐ Yes ☐ Not evaluated ☐ 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

FOLLOW UP

MED-B
SYSTEMIC 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

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		

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	☐	☐	☐	
Multior**Error! Objects cannot be created**	☐	☐	☐	
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

(ALLOS ONLY)

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	
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 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 / transplant)*:

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 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

DISEASE STATUS

Fill in this section only if evaluation has been performed less than 2 weeks prior to the* DATE OF LAST CONTACT OR DEATH *on this form.

☐ Limited (cutaneous thickening distal to elbows or knees, but not proximal)
☐ Diffuse
☐ SSc sine scleroderma
☐ Other (MCTD: Mixed Connective Tissue Disease)
☐ other, specify:_____

SKIN THICKNESS

Total modified Rodnan Skin Score (max 51). : ..... ☐ Not evaluated ☐ Unknown
(Appendix B. 10)

LABORATORY VALUES		**Units**		
Serum creatinine:	.....	(μmol/l)	☐ Not evaluated	☐ unknown
Creatinine clearance:	.....	(ml/min)	☐ Not evaluated	☐ unknown
Creatinine phosphokinase:	☐ Normal	☐ Elevated	☐ Not evaluated	☐ Unknown
Proteinuria: total urinary protein excretion _____		mg/24hrs	☐ Not evaluated	☐ Unknown

AUTOANTIBODIES

Were tests for autoantibodies done since last follow up? ☐ Yes ☐ No ☐ Unknown

SPECIFY ANTIBODY:

Anti-DNA topoisomerase I (Scl-70):	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-centromere (ACA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Anti-nuclear (ANA)	☐ Negative	☐ Positive	☐ Not evaluated	☐ unknown
Other, specify.....	☐ Negative	☐ Positive		

PHYSICAL EXAMINATION RESULTS

Dyspnoea on exertion ☐ No ☐ Yes ☐ Not evaluated ☐ Unknown

DLCO ..... (% predicted) ☐ Not evaluated ☐ Unknown

Restrictive pulmonary function pattern ☐ No ☐ Yes ☐ Not evaluated ☐ Unknown

Fibrosis on CXR ☐ No ☐ Yes ☐ Not evaluated ☐ Unknown

Pulmonary artery hypertension (ECHO) ☐ No ☐ Yes ☐ Not evaluated ☐ Unknown

Mean pulmonary arterial systolic pressure (PASP) .....mm/Hg ☐ Not evaluated ☐ Unknown

Systemic hypertension requiring treatment
- ☐ No
- ☐ Yes: ☐ With ACE Inhibitor
  ☐ With other, specify: .....
- ☐ Not evaluated
- ☐ Unknown

Arrhythmia / conduction blocks ☐ No ☐ Yes ☐ Not evaluated ☐ 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 *(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

.....

_____