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

HSCT - Minimum Essential Data – A CONTENT

REGISTRATION - DAY 0

ACUTE LEUKAEMIAS (main disease code 1)

CHRONIC LEUKAEMIAS (main disease code 2)

LYMPHOMAS (main disease code 3)

MYELODYSPLASTIC SYNDROME (MDS) (main disease code 6)

COMBINED MYELODYSPLASTIC SYNDROME/MYELOPROLIFERATIVE NEOPLASM (MDS/MPN) (main disease code 6)

MYELOPROLIFERATIVE NEOPLASMS (MPN) (main disease code 6)

PLASMA CELL DISORDERS INCLUDING MULTIPLE MYELOMA (PCD) (main disease code 4)

BONE MARROW FAILURE SYNDROMES INCLUDING APLASTIC ANAEMIA (BMF) (main disease code 7)

HAEMOGLOBINOPATHY (main disease code 11)

SOLID TUMOURS (main disease code 5)

PRIMARY IMMUNE DEFICIENCIES (main disease code 8)

INHERITED DISORDERS OF METABOLISM (main disease code 8)

PLATELET AND OTHER INHERITED DISORDERS (main disease code 8)

HISTIOCYTIC DISORDERS (main disease code 9)

AUTOIMMUNE DISORDERS (main disease code 10)

SECOND REPORT - 100 DAYS AFTER HSCT

FOLLOW UP REPORT - ANNUAL

CELL INFUSION (CI) SHEET

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: _____ *yyyy - mm - dd* First transplant for this patient?: ☐ Yes ☐ No

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 not to the transplant.

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

Date of birth: _____ *yyyy - mm - dd* Sex: ☐ Male ☐ Female
(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 ☐ 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 ☐ Multiple Sclerosis ☐ Systemic Lupus ☐ Systemic Sclerosis ☐ Haemoglobinopathy

☐ Other diagnosis, specify: _____

⇨ **Complete and attach the relevant Disease classification sheet with date of HSCT and disease status at HSCT, then continue to Performance Score below.**

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 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……

Type of HSCT (Autologous)

☐ **Autologous**

Source of the Stem cells *(check all that apply):*
☐ Bone marrow ☐ Peripheral blood
☐ Cord blood ☐ Other: _____

Graft manipulation ex-vivo
other than for RBC removal or volume reduction

☐ No ☐ Yes: Genetic manipulation of the graft: ☐ No ☐ Yes:

⇨ **IF AUTOLOGOUS, CONTINUE TO "CHRONOLOGICAL NUMBER OF HSCT"**

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 _____ OR Age at time of donation *(if date of birth not provided)*
yyyy - mm - dd
_____ _____*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 pag*
☐ 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)

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

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) Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify		☐ mg/m2	☐ mg/kg	
☐ Bleomycin		☐ mg/m2	☐ mg/kg	
☐ Busulfan ☐ Oral ☐ IV ☐ Both		☐ mg/m2	☐ mg/kg	☐ mg x hr/L ☐ micromol x min/L ☐ 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 ☐ micromol x min/L ☐ 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 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

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

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 .....

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

ACUTE LEUKAEMIAS (main disease code 1)
Acute Myeloid leukaemia (AML) (1 of 4)

Disease

Date of Initial Diagnosis: _____
yyyy - mm - dd

Classification:

AML with recurrent genetic abnormalities

- ☐ AML with t(8;21)(q22;q22); RUNX1-RUNX1T1
- ☐ AML with inv(16)(p13.1;q22) or t(16;16)(p13.1;q22); CBFB-MYH11
- ☐ Acute promyelocytic leukaemia with t(15;17)(q22;q12); PML/RARA
- ☐ AML with t(9;11) (p22;q23); MLLT3-MLL
- ☐ AML with t(6;9) (p23;q24); DEK-NUP214
- ☐ AML with inv(3) (q21;q26.2) or t(3;3) (q21;q26.2); RPN1-EVI1
- ☐ AML (megakaryoblastic) with t(1;22) (p13;q13); RBM15-MKL1
- ☐ AML with 11q23 (MLL) abnormalities
- ☐ AML with BCR-ABL1
- ☐ AML with mutated NPM1
- ☐ AML with biallelic mutation of CEBPA
- ☐ AML with mutated RUNX1
- ☐ AML with myelodysplasia related changes *(old "Acute leukaemia transformed from MDS or MDS/MPN"):*

Was there a previous diagnosis of MDS or MDS/MPN?

- ☐ No → *Continue to Predisposing condition below*
- ☐ Yes → *Fill in the* MYELODYPLASTIC SYNDROME (MDS) or MDS/MPN *until status at HSCT, then continue with Predisposing Condition below*

AML not otherwise categorised (NOS)

- ☐ AML with minimal differentiation (FAB M0)
- ☐ AML without maturation (FAB M1)
- ☐ AML with maturation (FAB M2)
- ☐ Acute myelomonocytic leukaemia (FAB M4)
- ☐ Acute monoblastic and monocytic leukaemia (FAB M5)
- ☐ Acute erythroid leukaemia (FAB M6)
- ☐ Acute megakaryoblastic leukaemia (FAB M7)
- ☐ Acute basophilic leukaemia
- ☐ Acute panmyelosis with myelofibrosis
- ☐ Myeloid sarcoma (Granulocytic sarcoma)
- ☐ Myeloid proliferations related to Down syndrome
- ☐ Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
- ☐ Therapy related myeloid neoplasia (old "Secondary Acute Leukaemia")
  Related to prior treatment but NOT after a previous diagnosis of MDS or MDS/MPN.

Predisposing Condition?

Skip this question if the AML is a Therapy related neoplasia

Did the recipient have a predisposing condition prior to the diagnosis of leukaemia?

- ☐ No
- ☐ Yes:
  - ☐ Aplastic anaemia
  - ☐ Fanconi anaemia
  - ☐ Bloom syndrome
  - ☐ Unknown

Donor Cell Leukaemia?

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

Is this a donor cell leukaemia ☐ No ☐ Yes ☐ Not evaluated

ACUTE LEUKAEMIAS (main disease code 1)
Acute Myeloid leukaemia (AML) (2 of 4)

Chromosome Analysis at Diagnosis

Chromosome analysis at diagnosis (All methods including FISH)

☐ Done: normal ☐ Done: abnormal ☐ Not done or failed ☐ Unknown

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

Monosomal karyotype: ☐ No ☐ Yes ☐ Unknown
(>= 2 autosomal monosomies or 1 autosomal monosomy + at least 1 structural abnormality)

You can transcribe the complete karyotype: ________________________________

OR

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

t(15;17)	☐ Absent ☐ Present ☐ Not evaluated
t(8;21)	☐ Absent ☐ Present ☐ Not evaluated
inv(16)/ t(16;16)	☐ Absent ☐ Present ☐ Not evaluated
11q23 abnormality type	☐ Absent ☐ Present ☐ Not evaluated
Fill only if 11q23 abnormality is Present:	
t(9;11)	☐ Absent ☐ Present ☐ Not evaluated
t(11;19)	☐ Absent ☐ Present ☐ Not evaluated
t(10;11)	☐ Absent ☐ Present ☐ Not evaluated
t(6;11)	☐ Absent ☐ Present ☐ Not evaluated
Other abn(11q23), specify: _ _ _ _ _	
3q26 (EVI1) abnormality type	☐ Absent ☐ Present ☐ Not evaluated
Fill only if 3q26 (EVI1) abnormality is Present:	
inv(3)/ t(3;3)	☐ Absent ☐ Present ☐ Not evaluated
t(2 ;3)(p21 ;q26)	☐ Absent ☐ Present ☐ Not evaluated
Other t(3q26)/EVI1 rearrangement, specify: _ _ _ _ _	☐ Absent ☐ Present ☐ Not evaluated
t(6;9)	☐ Absent ☐ Present ☐ Not evaluated
abn 5 type	☐ Absent ☐ Present ☐ Not evaluated
Fill only if above abn 5 is Present:	
del (5q)	☐ Absent ☐ Present ☐ Not evaluated
monosomy 5	☐ Absent ☐ Present ☐ Not evaluated
add(5q)	☐ Absent ☐ Present ☐ Not evaluated
Other abn(5q); please specify: _ _ _ _ _	☐ Absent ☐ Present ☐ Not evaluated
abn 7 type	☐ Absent ☐ Present ☐ Not evaluated
Fill only if abn 7 is Present:	
del(7q)	☐ Absent ☐ Present ☐ Not evaluated
monosomy 7	☐ Absent ☐ Present ☐ Not evaluated
add(7q)	☐ Absent ☐ Present ☐ Not evaluated
Other abn(7q); please specify: _ _ _ _ _	☐ Absent ☐ Present ☐ Not evaluated
-17	☐ Absent ☐ Present ☐ Not evaluated
abn(17p)	☐ Absent ☐ Present ☐ Not evaluated
t(1;22)	☐ Absent ☐ Present ☐ Not evaluated
trisomy 8	☐ Absent ☐ Present ☐ Not evaluated
Other, specify……………………………………………	☐ Absent ☐ Present

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

ACUTE LEUKAEMIAS **(main disease code 1)**
Primary Acute Myeloid leukaemia (AML) (3 of 4)

Molecular Markers at Diagnosis

Molecular marker analysis at diagnosis

☐ Not evaluated ☐ Evaluated: absent ☐ Evaluated present ☐ Unknown

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

AML1-ETO (RUNX1/RUNXT1) *Molecular product of t(8;21)*	☐ Absent ☐ Present ☐ Not evaluated
CBFB-MYH11 *Molecular product of inv(16)(p13.1;q22) or (16;16)(p13.1;q22)*	☐ Absent ☐ Present ☐ Not evaluated
PML-RARα *Molecular product of t(15;17)*	☐ Absent ☐ Present ☐ Not evaluated

MLL-rearrangement/mutation: *Fill only if 11q23 abnormality is Present:*	☐ Evaluated at least once	☐ Not evaluated
MLLT3(AF9)-MLL *molecular product of t(9;11)(p22;q23)*	☐ Absent ☐ Present ☐ Not evaluated	
MLL-PTD (partial tandem duplication)	☐ Absent ☐ Present ☐ Not evaluated	
MLLT4(AF6)-MLL *molecular product of t(6;11)(q27;q23)*	☐ Absent ☐ Present ☐ Not evaluated	
ELL-MLL: *molecular product of t(11;19)(q23;p13.1)*	☐ Absent ☐ Present ☐ Not evaluated	
MLLT1(ENL)-MLL: *molecular product of t(11;19)(q23;p13.3)*	☐ Absent ☐ Present ☐ Not evaluated	
MLLT10(AF10)-MLL: *molecular product of t(10;11)(p12;q23)*	☐ Absent ☐ Present ☐ Not evaluated	
Other MLL-rearrangement, specify: _ _ _ _ __ _ _ _ __ ____ _ _ __	☐ Absent ☐ Present ☐ Not evaluated	

DEK-NUP214(CAN) *molecular product of translocation t(6;9)(p23;q34)*	☐ Absent ☐ Present ☐ Not evaluated
RPN1-EVI1 *molecular product of inv(3)(q21q26.2) or t(3;3)(q21q26.2)*	☐ Absent ☐ Present ☐ Not evaluated
RBM15-MKL1 *molecular product of translocation t(1;22)(p13;q13)*	☐ Absent ☐ Present ☐ Not evaluated
NPM1 mutation	☐ Absent ☐ Present ☐ Not evaluated
CEBPA mutation	☐ Absent ☐ Present ☐ Not evaluated
FLT3-ITD (internal tandem duplication)	☐ Absent ☐ Present ☐ Not evaluated
DNMT3A	☐ Absent ☐ Present ☐ Not evaluated
ASXL1	☐ Absent ☐ Present ☐ Not evaluated
TP53	☐ Absent ☐ Present ☐ Not evaluated
RUNX1	☐ Absent ☐ Present ☐ Not evaluated
c-KIT	☐ Absent ☐ Present ☐ Not evaluated
Other, specify _ _ _ _ __ _ _ _ __ _ _ _ __ _ _ _ _	☐ Absent ☐ Present ☐ Not evaluated

Involvement at Diagnosis

Involvement at diagnosis

Bone marrow	☐ No	☐ Yes	☐ Not evaluated
CNS	☐ No	☐ Yes	☐ Not evaluated
Testis/ovary	☐ No	☐ Yes	☐ Not evaluated
Other	☐ No	☐ Yes, specify	

ACUTE LEUKAEMIAS**(main disease code 1)**
Primary Acute Myeloid leukaemia (AML) (4 of 4)

Status at HSCT

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

STATUS	**NUMBER**	**TYPE OF REMISSION**	
☐ Primary induction failure			
☐ Complete haematological remission (CR)	☐ 1st ☐ 2nd ☐ 3rd or higher	**CYTOGENETICS REMISSION** ☐ No ☐ Yes ☐ Not Evaluated ☐ Not Applicable* ☐ Unknown	**MOLECULAR REMISSION** ☐ No ☐ Yes ☐ Not Evaluated ☐ Not Applicable* ☐ Unknown
☐ Relapse	☐ 1st ☐ 2nd ☐ 3rd or higher		

** No abnormalities detected prior to this time point*

Date of last relapse before this HSCT: ----------
(If applicable) *yyyy - mm - dd*

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

ACUTE LEUKAEMIAS **(main disease code 1)**
Precursor lymphoid neoplasms (old ALL) (1 of 3)

Disease

Date of initial diagnosis _____
yyyy - mm - dd

Classification:

B lymphoblastic leukaemia/lymphoma (old Precursor B-cell ALL)

- ☐ with t(9;22)(q34;q11.2); BCR-ABL1
- ☐ with t(v;11q23); MLL rearranged
- ☐ with t(1;19)(q23;p13.3); E2A-PBX1
- ☐ with t(12;21)(p13;q22); TEL-AML1 (ETV-RUNX1)
- ☐ with hyperdiploidy
- ☐ with hypodiploidy
- ☐ with t(5;14)(q31;q32); IL3-IGH
- ☐ Not otherwise specified (NOS)
- ☐ Other._____

☐ T lymphoblastic leukaemia/lymphoma (old Precursor T-cell ALL)

Secondary Origin?

Secondary origin

Related to prior exposure to therapeutic drugs or radiation ☐ No ☐ Yes ☐ Unknown

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

Is this a donor cell leukaemia ☐ No ☐ Yes ☐ Not evaluated

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

ACUTE LEUKAEMIAS **(main disease code 1)**
Precursor lymphoid neoplasms (old ALL) 2 of 3

Chromosome Analysis at Diagnosis

Chromosome analysis at diagnosis (All methods including FISH)

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

If abnormal:

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

You can transcribe the complete karyotype: _____

OR

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

t(9;22)	☐ Absent	☐ Present	☐ Not evaluated
11q23 abnormalities *Fill only if 11q23 abnormalities is Present:*	☐ Absent	☐ Present	☐ Not evaluated
t(4;11)	☐ Absent	☐ Present	☐ Not evaluated
Other abn(11q23); please specify: _ _ _ _ _	☐ Absent	☐ Present	☐ Not evaluated
t(12;21)	☐ Absent	☐ Present	☐ Not evaluated
Hyperdiploidy (>46 chromosomes) *Fill only if hyperdiploidy is Present:*	☐ Absent	☐ Present	☐ Not evaluated
50 – 66 chromosomes	☐ Absent	☐ Present	☐ Not evaluated
Trisomy: Specify extra chromosome: _ _ _ _ _	☐ Absent	☐ Present	☐ Not evaluated
Other hyperdiploid karyotype ..... number of chromosomes .....:	☐ Absent	☐ Present	☐ Not evaluated
Hypodiploidy (<46 chromosomes): *specify the number of missing chromosomes:*	☐ Absent	☐ Present	☐ Not evaluated
Low hypodiploid, 32-39 chromosomes	☐ Absent	☐ Present	☐ Not evaluated
Near haploid, 24-31 chromosomes	☐ Absent	☐ Present	☐ Not evaluated
Monosomy. Specify: _ _ _ _ _	☐ Absent	☐ Present	☐ Not evaluated
Other. number of chromosomes _____	☐ Absent	☐ Present	☐ Not evaluated
t(5;14)(q31;q32)	☐ Absent	☐ Present	☐ Not evaluated
t(1;19)	☐ Absent	☐ Present	☐ Not evaluated
trisomy 8	☐ Absent	☐ Present	☐ Not evaluated
Other, specify	☐ Absent	☐ Present	☐ Not evaluated

Molecular Markers at Diagnosis

Marker analysis

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

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

BCR-ABL molecular product of t(9;22)(q34;q11.2)	☐ Absent	☐ Present	☐ Not evaluated
MLL-rearrangement/mutation:	☐ Absent	☐ Present	☐ Not evaluated
Fill only if MLL-rearrangement/mutation is Present:			
AFF1(AF4)-MLL molecular product of t(4;11)(q21;q23)	☐ Absent	☐ Present	☐ Not evaluated
MLLT1(ENL)-MLL molecular product of t(11;19)(q23;p13.3)	☐ Absent	☐ Present	☐ Not evaluated
MLLT3(AF9)-MLL molecular product of t(9;11)(p22;q23)	☐ Absent	☐ Present	☐ Not evaluated
Other MLL-rearrangement, specify: ……	☐ Absent	☐ Present	☐ Not evaluated
TEL(ETV6)-AML1(RUNX1) molecular product of t(12;21)(p13;q22)	☐ Absent	☐ Present	☐ Not evaluated
IL3-IGH molecular product of translocation t(5;14)(q31;q32)	☐ Absent	☐ Present	☐ Not evaluated
TCF3-PBX1 Molecular product of translocation (1;19)(q23 ;p13.3)	☐ Absent	☐ Present	☐ Not evaluated
IKZF1 (IKAROS)	☐ Absent	☐ Present	☐ Not evaluated
NOTCH1 & FBXW7	☐ Absent	☐ Present	☐ Not evaluated
Other, specify……	☐ Absent	☐ Present	☐ Not evaluated

ACUTE LEUKAEMIAS **(main disease code 1)**
Precursor lymphoid neoplasms (old ALL) 3 of 3

Status at HSCT

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

STATUS	**NUMBER**	**TYPE OF REMISSION**	
☐ Primary induction failure			
☐ Complete haematological remission (CR)	☐ 1st ☐ 2nd ☐ 3rd or higher	**CYTOGENETIC REMISSION** ☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown	**MOLECULAR REMISSION** ☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown
☐ Relapse	☐ 1st ☐ 2nd ☐ 3rd or higher		

** No abnormalities detected prior to this time point*

ACUTE LEUKAEMIAS **(main disease code 1)**
Other acute leukaemias

Disease

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

Classification:

Acute Leukaemias of ambiguous lineage

- ☐ Acute undifferentiated leukaemia
- ☐ Mixed phenotype NOS
  - ☐ Mixed phenotype B/myeloid, NOS
  - ☐ Mixed phenotype T/myeloid, NOS
- ☐ Natural killer (NK)- cell lymphoblastic leukaemia/lymphoma
- ☐ Other, specify.....

Secondary Origin?

Secondary origin

Related to prior exposure to therapeutic drugs or radiation

- ☐ No
- ☐ Yes
- ☐ Unknown

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

Is this a donor cell leukaemia ☐ No ☐ Yes ☐ Not evaluated

Status at HSCT

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

STATUS	**NUMBER**	**TYPE OF REMISSION**	
☐ Primary induction failure			
☐ Complete haematological remission (CR)	☐ 1st ☐ 2nd ☐ 3rd or higher	**CYTOGENETIC REMISSION** ☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown	**MOLECULAR REMISSION** ☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown
☐ Relapse	☐ 1st ☐ 2nd ☐ 3rd or higher		

** No abnormalities detected prior to this time point*

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

CHRONIC LEUKAEMIAS (main disease code 2)
Chronic Myelogenous Leukaemias (CML)

Disease

Date of Initial Diagnosis: _____
yyyy - mm - dd

Classification:*(CMML is not a CML but MDS/MPN*

At least one investigation must be positive

Translocation (9;22)	☐ Absent	☐ Present	☐ Not evaluated
bcr-abl	☐ Absent	☐ Present	☐ Not evaluated

Treatment Pre-HSCT

Treatment pre-HSCT (primary treatment)

☐ No - Includes supportive care or treatment without Tyrosine Kinase Inhibitor (TKI) or chemotherapy

☐ Yes Date Treatment started _____
yyyy - mm - dd

Tyrosine Kinase Inhibitor (TKI):
- ☐ No
- ☐ Yes
  - ☐ Imatinib mesylate
  - ☐ Nilotinib
  - ☐ Dasatinib
  - ☐ Bosutinib
  - ☐ Ponatinib
  - ☐ Other TKI, specify: _____

☐ Other chemotherapy, specify:_____

Status at HSCT

Date of this HSCT: _____
yyyy - mm - dd

PHASE	NUMBER	TYPE OF REMISSION		
		HAEMATOLOGICAL	**CYTOGENETIC**	**MOLECULAR**
☐ Chronic phase (CP)	☐ 1st ☐ 2nd ☐ 3rd or higher	☐ No ☐ Yes ☐ Not evaluated ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown	☐ No ☐ Yes ☐ Not evaluated ☐ Not Applicable* ☐ Unknown
☐ Accelerated phase	☐ 1st ☐ 2nd ☐ 3rd or higher			
☐ Blast crisis	☐ 1st ☐ 2nd ☐ 3rd or higher			

** No abnormalities detected prior to this time point*

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

CHRONIC LEUKAEMIAS (main disease code 2)

Chronic Lymphocytic leukaemias (CLL)

Disease

Date of Initial Diagnosis _____
yyyy - mm - dd

Classification:

☐ Chronic lymphocytic leukaemia (CLL)/small lymphocytic lymphoma

☐ 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)*

Chromosome Analysis at Diagnosis

Chromosome Analysis (All methods including FISH)

☐ Normal ☐ Abormal ☐ Not done or failed ☐ Unknown

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
Other, specify: _ _ _ _ _ _____	☐ Absent	☐ Present	☐ Not evaluated

Molecular Markers at Diagnosis

Molecular markers

TP53 mutations ☐ Absent ☐ Present ☐ Not Evaluated ☐ Unknown

Treatment Pre-HSCT

Treatment pre-HSCT (primary treatment)

☐ No

☐ Yes Date Treatment started _____
yyyy - mm - dd

Regimen	Date started	Date ended
- - - - - - - - - - - -	- - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - -	- - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - -	- - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -
	yyyy - mm - dd	*yyyy - mm - dd*

Status at HSCT

Date of this HSCT: _____
yyyy - mm - dd

STATUS	**Minimal residual disease (MRD)** *(by FACS or PCR)*
☐ Complete remission (CR) ☐ Partial remission (PR)	☐ Negative ☐ Positive ☐ Not evaluated
☐ Stable disease (SD) ☐ Untreated Relapse ☐ Progression (PD) ☐ Never treated	

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

CHRONIC LEUKAEMIAS (main disease code 2)
Prolymphocytic leukaemias (PLL & Other)

Disease

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

☐ Prolymphocytic Leukaemia (PLL)
- ☐ PLL, B-cell
- ☐ PLL, T-cell

☐ Hairy Cell Leukaemia

☐ Other, specify _____

PLL only Chromosome Analysis at Diagnosis

Chromosomal Analysis (All methods including FISH)

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

inv(14)/ 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: _ _ _ _ _ _____	☐ Absent	☐ Present	☐ Not evaluated

T-cell PLL only Immunophenotyping

Immunophenotyping of T-cells

NOTE: TdT *(Terminal deoxynucleotidyl transferase)* must be negative

CD4+	☐ No	☐ Yes	☐ Not Evaluated
CD8+	☐ No	☐ Yes	☐ Not Evaluated

Lymphocyte count …… 10^9cells/L

Status at HSCT

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

STATUS:

☐ Complete remission (CR)
☐ Partial remission (PR)
☐ Stable disease (SD)
☐ Untreated Relapse
☐ Progression (PD)
☐ Never treated

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

LYMPHOMAS (main disease code 3)

B-Cell Non Hodgkin Lymphomas (NHL)

Disease

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

B-Cell Neoplasms	
☐ Splenic marginal zone lymphoma	
☐ Extranodal marginal zone lymphoma of mucosa associated lymphoid tissue (MALT)	
☐ Nodal marginal zone lymphoma	
☐ Lymphoplasmacytic lymphoma (LPL)	
☐ Waldenstrom macroglobulinaemia (LPL with monoclonal IgM)	**International Prognostic Scoring System for Waldenström's Macroglobulinemia (ISSWM)** ☐ Low risk (0-1 score points except age >65) ☐ High risk (3-5) ☐ Intermediate risk (score 2 or age >65 alone) ☐ Not evaluated
☐ Follicular lymphoma	**Grading** ☐ Grade I ☐ Grade II ☐ Grade III ☐ Not evaluated **Prognostic score (FLIPI)** ☐ Low risk ☐ Intermediate risk ☐ High risk ☐ Not evaluated
☐ Primary cutaneous follicle centre lymphoma	
☐ Mantle cell lymphoma	**Grading** ☐ indolent ☐ classical ☐ pleomorphic ☐ blastoid ☐ Not evaluated **Prognostic score (MIPI)** ☐ Low risk ☐ Intermediate risk ☐ High risk ☐ Not evaluated KI-67 (Proliferation index) __ __ % Positive ☐ Not evaluated
☐ Diffuse large B-cell lymphoma (DLBCL), (NOS)	**International Prognostic Index (IPI)** ☐ Low risk (0-1 score points) ☐ Low-Intermediate risk (2) ☐ High-intermediate risk (3) ☐ High risk (4-5) ☐ Not evaluated KI-67 (Proliferation index) __ __ % Positive ☐ Not evaluated
☐ T-cell/histiocyte rich large B cell lymphoma	
☐ Primary DLBCL of the CNS	
☐ Primary cutaneous DLBCL, leg type	
☐ EBV positive DLBCL of the elderly	
☐ DLBCL associated with chronic inflammation	
☐ Lymphomatoid granulomatosis	
☐ Primary mediastinal (thymic) large B-cell lymphoma	
☐ Intravascular large B-cell lymphoma	
☐ ALK positive large B-cell lymphoma	
☐ Plasmablastic lymphoma	
☐ Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease	
☐ Primary effusion lymphoma (PEL)	
☐ Burkitt lymphoma (BL)	
☐ B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma (Intermediate DLCBL/BL)	
☐ B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and classical Hodgkin lymphoma (Intermediate DLCBL/HD)	
☐ Other B-cell, specify:_____	

Transformed from another type of lymphoma

☐ No
☐ Yes Date of original diagnosis .....
yyyy - mm - dd
Indicate the type of the original lymphoma ....
☐ Unknown

LYMPHOMAS (main disease code 3)
T-Cell Non Hodgkin Lymphomas (NHL)

Disease

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

Mature T-cell & NK-cell Neoplasms	
☐ T-cell large granular lymphocytic leukaemia	
☐ Aggressive NK-cell leukaemia	
☐ Systemic EBV positive T-cell lymphoproliferative disease of childhood	
☐ Hydroa vacciniforme-like lymphoma	
☐ Adult T-cell leukaemia/lymphoma	
☐ Extranodal NK/T-cell lymphoma, nasal type	
☐ Enteropathy-associated T-cell lymphoma	
☐ Hepatosplenic T-cell lymphoma	
☐ Subcutaneous panniculitis-like T-cell lymphoma	
☐ Mycosis fungoides (MF) ☐ Sézary syndrome	**ISCL/EORTC** ☐ I A ☐ I B ☐ II A ☐ II B ☐ III A ☐ III B ☐ IVA1 ☐ IVA2 ☐ IVB ☐ Not evaluated
☐ Lymphomatoid papulosis ☐ Primary cutaneous anaplastic large cell lymphoma ☐ Primary cutaneous gamma-delta T-cell lymphoma ☐ Primary cutaneous CD8 positive aggressive epidermotropic cytotoxic T-cell lymphoma ☐ Primary cutaneous CD4 positive small/medium T-cell lymphoma	
☐ Peripheral T-cell lymphoma NOS (PTCL) ☐ Angioimmunoblastic T-cell lymphoma ☐ Anaplastic large-cell lymphoma (ALCL), ALK-positive ☐ Anaplastic large-cell lymphoma (ALCL), ALK-negative ☐ Other T-cell, specify:_____	**International Prognostic Index (IPI)** ☐ Low risk (0-1 score points) ☐ Low-Intermediate risk (2) ☐ High-intermediate risk (3) ☐ High risk (4 or 5) ☐ Not evaluated

LYMPHOMAS (main disease code 3)

Hodgkin Lymphomas

Disease

Date of Initial Diagnosis: _____
yyyy - mm - dd

Classification:

- ☐ Nodular lymphocyte predominant
- ☐ Classical predominant
- ☐ Other , specify:_____

ALL LYMPHOMAS

Treatment Pre-HSCT

Treatment pre-HSCT *Enter first day of treatment and mark all drugs from that date until conditioning*

☐ No
☐ Yes Date of treatment ----------
yyyy - mm - dd

Drugs given

		Relapse/progression under this drug		
		Yes	**No**	**Unknown**
Antibodies:	☐ Alemtuzumab (MabCampath) (CD52)			
	☐ Brentuximab (Adcetris) (CD30)			
	☐ Obinutuzumab (Gyzeva) (CD20)			
	☐ Ofatumumab (Azerra) (CD20)			
	☐ Rituximab (Mabthera) (CD20)			
	☐ other antibody, specify_____			
Radioimmunotherapy:	☐ Bexxar (CD20) (radiolabelled MoAB)			
	☐ Zevalin (CD20) (radiolabelled MoAB)			
Specific inhibitors:	☐ ABT-199 (BCL2-Inhibitor)	☐	☐	☐
	☐ Crizotinib (ALK-Inhibitor)	☐	☐	☐
	☐ CC-292 (B cell receptor kinase inhibitor)	☐	☐	☐
	☐ Ibrutinib (B cell receptor kinase inhibitor)	☐	☐	☐
	☐ Idelalisib (B cell receptor kinase inhibitor)	☐	☐	☐
	☐ other inhibitor, specify_____	☐	☐	☐
Other:	☐ Bortezomib (Velcade)			
	☐ Lenalidomide (Revlimid)			
	☐ Other, specify _____			

Selected B-Cell Non Hodgkin Lymphomas (NHL)

Please complete this section for patients given HSCT for the following types of B-cell NHL:

- **Mantle cell lymphoma**
- **Waldenstrom macroglobulinaemia**
- **Burkitt lymphoma OR "Intermediate DLBCL/ Burkitt Lymphoma"**

Chromosome Analysis at any time before HSCT

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

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

If abnormal, please complete this table according to the type of lymphoma diagnosed

	Abnormality	Absent	Present	FISH used	Not Evaluated
Mantle cell lymphoma or Waldenstrom macroglobulinaemia	del 17p	☐	☐	☐ No ☐ Yes	☐
BL or "Intermediate DLCBL/Burkitt Lymphoma"	t(2;8)	☐	☐		☐
	t(8;14)	☐	☐		☐
	t(8;22)	☐	☐		☐
	t(14;18)	☐	☐		☐
	myc rearrangement	☐	☐		☐
	BCL-2 rearrangement	☐	☐		☐
	BCL-6 rearrangement	☐	☐		☐

Immunophenotyping at any time before HSCT

Immunophenotype / immunochemistry analysis at any time before HSCT

Immunophenotyping done? ☐ No ☐ Yes ☐ Unknown

Provide answers according to the type of lymphoma diagnosed

	Phenotype	Present	Absent	Not Evaluated
Mantle cell lymphoma	SOX 11	☐	☐	☐
Burkitt Lymphoma or "Intermediate DLCBL/Burkitt Lymphoma"	MYC	☐	☐	☐
"Intermediate DLCBL/Burkitt Lymphoma"	BCL-2/IgH	☐	☐	☐
	BCL-6	☐	☐	☐

Molecular Markers at any time before HSCT

Molecular marker analyses (i.e. PCR) at any time before HSCT

☐ Not evaluated ☐ Present ☐ Absent ☐ Unknown

Provide answers according to the type of lymphoma diagnosed

	Marker	Present	Absent	Not Evaluated
Mantle cell lymphoma	TP53 mutation	☐	☐	☐
Burkitt Lymphoma or "Intermediate DLCBL/Burkitt Lymphoma"	*myc* rearrangement	☐	☐	☐
"Intermediate DLCBL/Burkitt Lymphoma"	*BCL-2* rearrangement	☐	☐	☐
	BCL-6 rearrangement	☐	☐	☐

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

ALL LYMPHOMAS

Status at HSCT

Date of this HSCT: _____
yyyy - mm - dd

Number of prior lines of treatment ☐ 1 ☐ 2 ☐ 3 or more:___ ☐ none ☐ Unknown

(since diagnosis if 1st transplant, or since last reported transplant)

Technique used for disease assessment:

CT scan done ☐ No ☐ Yes

PET ☐ Negative ☐ Positive ☐ Not evaluated

STATUS

- ☐ Never treated
- ☐ Complete remission (CR)
  - ☐ Unconfirmed (CRU*) ☐ Confirmed
  - *CRU – complete response with persistent scan abnormalities of unknown significance
- ☐ Partial response (PR) – (with or without a prior CR)
- ☐ Stable disease
- ☐ Untreated relapse (from a previous CR) / untreated progression (from a previous PR)
- ☐ Chemorefractory relapse or progression, including primary refractory disease
- ☐ Disease status unknown

Was this patient refractory to any line of chemotherapy before this HSCT? ☐ No ☐ Yes

Number of Complete (CR, CRu) achieved by the patient prior to this HSCT: _____
Count <u>all</u> CR including this one if applicable

Number of Partial remissions (PR) achieved by the patient prior to this HSCT: _____
Count <u>all</u> PR including this one if applicable

MYELODYSPLASTIC SYNDROME (MDS)(main disease code 6)

Disease

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

Select only one

WHO Classification at diagnosis:

- ☐ Refractory anaemia *(without ring sideroblasts) (RA)*
- ☐ RA with ring sideroblasts (RARS)
- ☐ MDS associated with isolated del(5q)
- ☐ Refractory cytopenia with multilineage dysplasia (RCMD)
- ☐ RCMD with ringed sideroblasts (RCMD-RS)
- ☐ RA with excess of blasts-1 (RAEB-1)
- ☐ RA with excess of blasts-2 (RAEB-2)
- ☐ Childhood myelodysplastic syndrome *(Refractory cytopenia of childhood (RCC))*
- ☐ MDS Unclassifiable (MDS-U)

Secondary Origin?

Therapy related MDS:
(Secondary origin)

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

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

Is this a donor cell leukaemia ☐ No ☐ Yes ☐ Not evaluated

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

MYELODYSPLASTIC SYNDROME (MDS)(main disease code 6)

Chromosome Analysis at Diagnosis

Chromosome analysis at diagnosis (All methods including FISH)

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ 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:

del Y (-Y)	☐ Absent ☐ Present ☐ Not evaluated
abn 5 type *Fill only if abn 5 is Present*	☐ Absent ☐ Present ☐ Not evaluated
del5q (5q-)	☐ Absent ☐ Present ☐ Not evaluated
Other abn 5, specify _ _ _ _ _ _ _ _	☐ Absent ☐ Present ☐ Not evaluated
del 20q (20q-)	☐ Absent ☐ Present ☐ Not evaluated
abn 7 type *Fill only if abn 7 is Present:*	☐ Absent ☐ Present ☐ Not evaluated
del 7q (7q-)	☐ Absent ☐ Present ☐ Not evaluated
Other abn 7, specify	☐ Absent ☐ Present ☐ Not evaluated
abn 3 type *Fill only if abn 3 is Present:*	☐ Absent ☐ Present ☐ Not evaluated
inv(3)	☐ Absent ☐ Present ☐ Not evaluated
t(3q;3q)	☐ Absent ☐ Present ☐ Not evaluated
del(3q)	☐ Absent ☐ Present ☐ Not evaluated
Other abn 3, specify	☐ Absent ☐ Present ☐ Not evaluated
del11q	☐ Absent ☐ Present ☐ Not evaluated
trisomy 8	☐ Absent ☐ Present ☐ Not evaluated
trisomy 19	☐ Absent ☐ Present ☐ Not evaluated
i(17q)	☐ Absent ☐ Present ☐ Not evaluated
Other, specify	☐ Absent ☐ Present ☐ Not evaluated

Molecular Markers at Diagnosis

Marker analysis at diagnosis

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

*If you are entering an **AML with myelodyplasia related changes,** return to the Acute Leukaemia to continue*

MYELODYSPLASTIC SYNDROME (MDS)(main disease code 6)

Status at HSCT

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

Select only one

WHO Classification at HSCT:

- ☐ Refractory anaemia (RA) (without ring sideroblasts)
- ☐ RA with ring sideroblasts (RARS)
- ☐ MDS associated with isolated del(5q)
- ☐ Refractory cytopenia with multilineage dysplasia (RCMD)
- ☐ RCMD with ringed sideroblasts (RCMD-RS)
- ☐ RA with excess of blasts-1 (RAEB-1)
- ☐ RA with excess of blasts-2 (RAEB-2)
- ☐ Childhood myelodysplastic syndrome (Refractory cytopenia of childhood (RCC))
- ☐ MDS Unclassifiable (MDS-U)

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

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

COMBINED MYELODYPLASTIC SYNDROME/ MYELOPROLIFERATIVE NEOPLASM (MDS/MPN) (main disease code 6)

Disease

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

Classification:

- ☐ Chronic myelomonocytic leukaemia (CMMoL, CMML)
- ☐ Juvenile myelomonocytic leukaemia (JCMMoL, JMML, JCML, JCMML)
- ☐ Atypical CML ((t(9;22) negative and BCR-ABL1 negative)

Therapy related MDS/ MPN: *(Secondary origin)*

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

Chromosome Analysis at Diagnosis

Chromosome analysis at diagnosis (All methods including FISH)

☐ Abnormal ☐ Normal ☐ Not done or failed ☐ 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 abnormalities that have been **evaluated** and whether they were **Absent**or **Present**

BCR-ABL; molecular product of t(9;22)(q34;q11.2)	☐ Absent ☐ Present ☐ Not evaluated
JAK2 mutation	☐ Absent ☐ Present ☐ Not evaluated
FIP1L1-PDGFR	☐ Absent ☐ Present ☐ Not evaluated
PTPN-11	☐ Absent ☐ Present ☐ Not evaluated
K-RAS	☐ Absent ☐ Present ☐ Not evaluated
N-RAS	☐ Absent ☐ Present ☐ Not evaluated
CBL	☐ Absent ☐ Present ☐ Not evaluated
Other _____	☐ Absent ☐ Present ☐ Not evaluated

COMBINED MYELODYPLASTIC SYNDROME/ MYELOPROLIFERATIVE NEOPLASM (MDS/MPN) (main disease code 6)

Status at HSCT

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

WHO Classification at HSCT:

- ☐ Chronic myelomonocytic leukaemia (CMMoL, CMML)
- ☐ Juvenile myelomonocytic leukaemia (JCMMoL, JMML, JCML, JCMML)
- ☐ Atypical CML ((t(9;22) negative and BCR-ABL1 negative)

STATUS

CMML/ Atypical CML

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

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: .....
yyyy - mm - dd

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: ☐ Primary refractory phase (no change)	
☐ Complete remission (CR)	☐ 1st ☐ 2nd ☐ 3rd or higher
☐ Improvement but no CR	
☐ Relapse (after CR)	☐ 1st ☐ 2nd ☐ 3rd or higher
☐ Progression/worse ☐ Never treated (Supportive care or treatment without chemotherapy)	

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

PLASMA CELL DISORDERS INCLUDING MULTIPLE MYELOMA (PCD) (main disease code 4)

Disease

Date of Initial Diagnosis: _____
yyyy - mm - dd

Classification:

- ☐ Multiple myeloma (MM)
  - ☐ MM - heavy chain and light chain
  - ☐ MM - light chain
  - ☐ MM - non-secretory
- ☐ Plasma cell leukaemia
- ☐ Solitary plasmacytoma of bone
- ☐ Primary amyloidosis
- ☐ POEMS
- ☐ Monoclonal light and heavy chain deposition disease (LCDD/HCDD)
- ☐ Other, specify _____

Check light and heavy chain types →
Check light chain type only →

HEAVY CHAIN TYPE	LIGHT CHAIN TYPE
☐ IgG	☐ Kappa
☐ IgA	☐ Lambda
☐ IgD	
☐ IgE	
☐ IgM *(not Waldenstrom)*	

Staging for Multiple myeloma only
SALMON & DURIE STAGE
(optional)

(PLEASE TICK EACH COLUMN)	
Stage	*Symptoms*
☐ I	☐ A
☐ II	☐ B
☐ III	

ISS STAGE

	β2-μglob mg/L)		*Albumin (g/L)*
☐ I	< 3.5		>35
☐ II	< 3.5	OR	< 35
	3.5 - < 5.5		any
☐ III	> 5.5		any

Chromosome Analysis at Diagnosis (not for Primary amyloidosis)

Chromosome analysis at diagnosis (All methods including FISH)

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ 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**

Del 13q14	☐ Absent	☐ Present	☐ Not evaluated
t(11;14)	☐ Absent	☐ Present	☐ Not evaluated
abn 17q	☐ Absent	☐ Present	☐ Not evaluated
del 17p	☐ Absent	☐ Present	☐ Not evaluated
t(4:14)	☐ Absent	☐ Present	☐ Not evaluated
t(14:16)	☐ Absent	☐ Present	☐ Not evaluated
1q amplification	☐ Absent	☐ Present	☐ Not evaluated
myc rearrangement	☐ Absent	☐ Present	☐ Not evaluated
Other, specify _____	☐ Absent	☐ Present	☐ Not evaluated

Molecular Markers at Diagnosis (not for Primary amyloidosis)

Marker analysis at diagnosis

☐ Absent ☐ Present ☐ Not Evaluated ☐ Unknown

PLASMA CELL DISORDERS INCLUDING MULTIPLE MYELOMA (PCD)
(main disease code 4)

Status At HSCT

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

STATUS	**NUMBER**
☐ Never treated	
☐ Stringent complete remission (sCR) ☐ Complete remission (CR) ☐ Very good partial remission (VGPR) ☐ Partial remission (PR) ☐ Relapse from CR (untreated)	☐ 1st ☐ 2nd ☐ 3rd or higher
☐ Progression ☐ No change / stable disease	

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

BONE MARROW FAILURE SYNDROMES INCLUDING APLASTIC ANAEMIA (BMF)
(main disease code 7)

Disease

Date of initial diagnosis _____
yyyy - mm - dd

Classification:

Acquired:

- ☐ Aplastic Anaemia (SAA),
- ☐ Amegakaryocytosis, acquired (not congenital)
- ☐ Acquired Pure Red Cell Aplasia (PRCA) (not congenital)
- ☐ Paroxysmal nocturnal haemoglobinuria (PNH)
- ☐ Acquired Pure White Cell Aplasia
- ☐ Other acquired cytopenic syndrome, specify: _____

Etiology:
- ☐ Secondary to hepatitis
- ☐ Secondary to toxin/other drug
- ☐ Idiopathic
- ☐ Other, specify: _____

Congenital:

- ☐ Amegakaryocytosis / thrombocytopenia
- ☐ Fanconi anaemia
- ☐ Diamond-Blackfan anaemia (congenital PRCA)
- ☐ Shwachman-Diamond Syndrome
- ☐ Dyserythropoietic anaemia
- ☐ Dyskeratoris congenita
- ☐ Other congenital anaemia, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

HAEMOGLOBINOPATHY (main disease code 11)

Disease

Date of initial diagnosis _____
yyyy - mm - dd

Classification:

- ☐ Thalassaemia ☐ Beta 0 ☐ Beta + ☐ Beta E ☐ Beta S (sickle cell + thalassaemia)
- ☐ Sickle cell disease % sickle cell = ...
- ☐ Other haemoglobinopathy, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

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

SOLID TUMOURS (main disease code 5)

Disease

Date of initial diagnosis _____
yyyy - mm - dd

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:_____

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
☐	☐	☐	☐	☐	☐

Risk Factors/Staging at Diagnosis

Breast carcinoma only

Receptor status:

Estrogen (ER): ☐ Negative ☐ Positive ☐ Not evaluated

Progesteron (PgR): ☐ Negative ☐ Positive ☐ Not evaluated

HER2/neu (c-erb-B2): ☐ Negative ☐ Positive ☐ Not evaluated

Axillary lymph nodes at surgery: N° positive / N° examined = ... / ....

Sentinel Node ☐ Negative ☐ Positive ☐ Not evaluated

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:.....

SOLID TUMOURS (main disease code 5)

Status At HSCT

Date of this HSCT: _____
yyyy - mm - dd

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

☐ Adjuvant
☐ Never treated (upfront)
☐ Stable disease/no response

☐ Complete remission (CR) ☐ Unconfirmed (CRU*) *CRU – complete response with persistent scan abnormalities of unknown significance ☐ Confirmed	**NUMBER** ☐ 1st ☐ 2nd ☐ 3rd or higher
☐ 1st Partial response (PR1)	

☐ Relapse	**NUMBER** ☐ 1st ☐ 2nd ☐ 3rd or higher	**SENSITIVITY TO CHEMOTHERAPY** ☐ Sensitive ☐ Resistant ☐ Untreated
☐ Progressive disease (PD)		

Organs involved *(complete only if not in CR)*

☐ Nodes
☐ CNS
☐ Liver
☐ Bone
☐ Lung
☐ Soft Tissue

☐ Other, specify:.....

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

PRIMARY IMMUNE DEFICIENCIES (main disease code 8)

Disease

Date of initial diagnosis: _____
yyyy - mm - dd

Classification:

- ☐ Absence of T and B cells SCID
- ☐ Absence of T, normal B cell SCID
- ☐ ADA deficiency (Adenosine deaminase deficiency)
- ☐ Ataxia telangiectasia
- ☐ Bare lymphocyte syndrome
- ☐ Cartilage hair hypoplasia
- ☐ CD 40 Ligand deficiency
- ☐ Chediak-Higashi syndrome
- ☐ Chronic granulomatous disease
- ☐ Common variable immunodeficiency
- ☐ DiGeorge anomaly
- ☐ Immune deficiencies, not otherwise specified
- ☐ Kostmann syndrome-congenital neutropenia
- ☐ Leukocyte adhesion deficiencies
- ☐ Neutrophil actin deficiency
- ☐ Omenn syndrome
- ☐ PNP deficiency Purine nucleoside phosphorylase deficiency)
- ☐ Reticular dysgenesis
- ☐ SCID other, specify: _____
- ☐ SCID, unspecified
- ☐ Wiskott Aldrich syndrome
- ☐ X-linked lymphoproliferative syndrome
- ☐ Other, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

INHERITED DISORDERS OF METABOLISM (main disease code 8)

Disease

Date of initial diagnosis: _____
yyyy - mm - dd

Classification:

- ☐ Adrenoleukodystrophy
- ☐ Aspartyl glucosaminuria
- ☐ B-glucuronidase deficiency (VII)
- ☐ Fucosidosis
- ☐ Gaucher disease
- ☐ Glucose storage disease
- ☐ Hunter syndrome (II)
- ☐ Hurler syndrome (IH)
- ☐ I-cell disease
- ☐ Krabbe disease (globoid leukodystrophy)
- ☐ Lesch-Nyhan (HGPRT deficiency)
- ☐ Mannosidosis
- ☐ Maroteaux-Lamy (VI)
- ☐ Inherited disorders of metabolism, not otherwise specified
- ☐ Metachromatic leukodystrophy
- ☐ Morquio (IV)
- ☐ Mucolipidoses, unspecified
- ☐ Mucopolysaccharidosis (V)
- ☐ Mucopolysaccharidosis, unspecified
- ☐ Niemann-Pick disease (Type A,B)
- ☐ Niemann-Pick disease (Type C,D,E)
- ☐ Neuronal ceroid – lipofuscinosis (Batten disease)
- ☐ Polysaccharide hydrolase abnormalities, unspecified
- ☐ Sanfilippo (III)
- ☐ Scheie syndrome (IS)
- ☐ Wolman disease
- ☐ Other, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

PLATELET AND OTHER INHERITED DISORDERS (main disease code 8)

Disease

Date of initial diagnosis _____
yyyy - mm - dd

Classification:

- ☐ Glanzmann thrombasthenia
- ☐ Other inherited platelet abnormalities, specify: _____

- ☐ Osteopetrosis (malignant infantile osteopetrosis)
- ☐ Other osteoclast defects, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

HISTIOCYTIC DISORDERS (main disease code 9)

Disease

Date of initial diagnosis: _____
yyyy - mm - dd

Classification:

- ☐ Histiocytic disorders, not otherwise specified
- ☐ Familial erythro/haemophagocytic lymphohistiocytosis (FELH)
- ☐ Langerhans Cell Histiocytosis *(Histiocytosis-X)*
- ☐ Haemophagocytosis (reactive or viral associated)
- ☐ Histiocytic sarcoma *(malignant histiocytosis)*
- ☐ Other, specify: _____

HSCT

Date of this HSCT: _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS (main disease code 10)

CONNECTIVE TISSUE DISEASE

Date of initial diagnosis _____
yyyy - mm - dd

Classification:

☐ Systemic sclerosis (SS)

Involvement/Clinical problem

- ☐ diffuse cutaneous
- ☐ limited cutaneous
- ☐ SSc sine scleroderma
- ☐ Mixed Connective Tissue Disease (MCTD)
- ☐ other, specify:_____

Status at mobilisation:

Date of the first mobilisation or collection _____
yyyy - mm - dd

Performance: system used ☐ Karnofsky ☐ Lansky

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

Creatinine clearance (Cockroft formula) _____ ml/min

Proteinuria _____ g/24hrs

Modified Rodnan Skin Score (0-51) _____

DLCO _____

Pulmonary Arterial Systolic Pressure [PASP] _____ mm Hg

GI involvement ☐ No ☐ Yes ☐ Not evaluated

Date of this HSCT: _____
yyyy - mm - dd

☐ Systemic lupus erythematosus (SLE)

Status at mobilisation:

Date of the first mobilisation _____
yyyy - mm - dd

SLEDAI Score _____

Date of this HSCT: _____
yyyy - mm - dd

- ☐ Polymyositis- dermatomyositis
- ☐ Sjögren syndrome
- ☐ Antiphospholipid syndrome
- ☐ Other type of connective tissue disease, specify:_____

Date of this HSCT: _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS (main disease code 10)

VASCULITIS / ARTHRITIS / NEUROLOGICAL

Date of initial diagnosis _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS – VASCULITIS

- ☐ Wegener granulomatosis
- ☐ Classical polyarteritis nodosa
- ☐ Microscopic polyarteritis nodosa
- ☐ Churg-Strauss
- ☐ Giant cell arteritis
- ☐ Takayasu
- ☐ Behçet syndrome
- ☐ Overlap necrotising arteritis
- ☐ Other, specify:_____

Date of this HSCT: _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS – ARTHRITIS

- ☐ Rheumatoid arthritis
- ☐ Psoriatic arthritis/psoriasis
- ☐ Juvenile idiopathic arthritis (JIA), systemic (Stills disease)
- ☐ Juvenile idiopathic arthritis (JIA), articular: Onset ☐ Oligoarticular ☐ Polyarticular
- ☐ Juvenile idiopathic arthritis: other, specify:_____
- ☐ Other arthritis: .....

Date of this HSCT: _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS – NEUROLOGICAL DISEASES

☐ MULTIPLE SCLEROSIS

Status at mobilisation:

Date of the first mobilisation _____
yyyy - mm - dd

Status at mobilisation:
- ☐ primary progressive
- ☐ secondary progressive
- ☐ relapsing/remitting
- ☐ other:_____

EDSS (1-10) _____ ☐ Not evaluated

Number of gadolinium enhancing lesions present on MRI Brain Scan: _____ ☐ Not evaluated

- ☐ Myasthenia gravis
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Chronic inflammatory demyelinating polyneuropathy (CIDP)
- ☐ Neuromyelitis Optica (NMO)
- ☐ Other autoimmune neurological disorder, specify:_____

Date of this HSCT: _____
yyyy - mm - dd

AUTOIMMUNE DISORDERS (main disease code 10)

OTHER AUTOIMMUNE DISORDERS

Date of initial diagnosis: _____
yyyy - mm - dd

HAEMATOLOGICAL DISEASES

- ☐ Idiopathic thrombocytopenic purpura (ITP)
- ☐ Haemolytic anaemia
- ☐ Evan syndrome
- ☐ Autoimmune lymphoproliferative syndrome (primary diagnosis, not subsequent to transplant)
- ☐ Other haematological autoimmune disease, specify: _____

Date of this HSCT: _____
yyyy - mm - dd

BOWEL DISEASE

- ☐ Crohn's disease

Status at mobilisation:

Date of the first mobilisation _____
yyyy - mm - dd

CDAI (0-700) _____

Serum albumin _____ g/L

- ☐ Ulcerative colitis
- ☐ Other autoimmune bowel disease, specify: _____

Date of this HSCT: _____
yyyy - mm - dd

OTHER AUTOIMMUNE

- ☐ Grave's disease
- ☐ other autoimmune, specify: _____

Date of this HSCT: _____
yyyy - mm - dd

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

HSCT - Minimum Essential Data - A

SECOND REPORT - 100 DAYS AFTER HSCT

Disease

PRIMARY DISEASE DIAGNOSIS……

Centre Identification

EBMT Code (CIC): _____ Contact person: _____

Hospital: _____ Unit: _____ Email: _____

Patient Data

Date of this report: _____
yyyy - mm - dd

Hospital Unique Patient Number/ Code: _____
(Compulsory, registrations will not be accepted without this item)

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

Date of birth _____
yyyy - mm - dd

Sex ☐ Male ☐ Female
(at birth)

Date of the transplant: _____
yyyy - mm - dd

Recovery

Absolute neutrophil count (ANC) recovery *(Neutrophils ≥ 0.5 x 10^9/L; first of 3 consecutive values after 7 days without any transfusion containing neutrophils)*

☐ No: Date of last assessment: _____
yyyy - mm - dd

☐ Yes: Date of ANC recovery: _____
yyyy - mm - dd

☐ Never below

☐ Unknown

Platelet reconstitution *(Platelets ≥ 20 x 10^9/L; first of 3 consecutive values after 7 days without transfusion)*

☐ No

☐ Yes: Date Platelets ≥ 20 x 10^9/l _____
yyyy - mm - dd

☐ Never below this level

☐ Date unknown: patient discharged before levels reached

☐ Date unknown: out-patient

☐ Unknown

Early graft loss *(Engraftment followed by loss of graft within the first 100 days)*

☐ No

☐ Yes

☐ Unknown

Acute GvHD (Allografts)

Acute Graft Versus Host Disease *(Allografts only)*

Maximum Grade:

☐ 0 (none) ☐ I ☐ II ☐ III ☐ IV ☐ Present but grade unknown ☐ Not evaluated

Date of onset _____
yyyy - mm - dd

Stage:

Skin	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Liver	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Lower GI tract	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Upper GI tract	☐ 0 (none)	☐ 1			
Other site affected	☐ No	☐ Yes			

Additional Cell Infusions

Additional cell infusions ***(excluding a new HSCT)***

☐ No

☐ Yes:

Is this cell infusion an allogeneic boost? ☐ No ☐ Yes: *- Skip Cell therapy table below*

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: *- Skip Cell therapy table below*

If the cell infusion is **not** a boost fill in the **Cell therapy** section below:

Cell therapy

First date of the cell therapy infusion _____
yyyy - mm - dd

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

Type of cell(s): *(check all that apply)*

☐ Lymphocyte *(DLI)* ☐ Mesenchymal ☐ Fibroblasts ☐ Dendritic cells
☐ NK cells ☐ Regulatory T-cells ☐ Gamma/delta cells ☐ Other, specify _____

Chronological number of the cell infusion episode for this patient _____

Indication: *(check all that apply)*

☐ Planned/protocol
☐ Prophylactic
☐ Treatment of GvHD
☐ Loss/decreased chimaerism
☐ Treatment PTLD, EBV lymphoma
☐ Other, specify: _____
☐ Treatment for disease
☐ Mixed chimaerism
☐ Treatment viral infection

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

Additional Disease Treatment

Additional disease treatment given *(excluding cell infusion)*

☐ No

☐ Yes: Reason for this additional treatment

☐ Prophylaxis / prevention *(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

Best response

Best disease status (response) after HSCT

(prior to any treatment modification in response to a post HSCT disease assessment)

This field is <u>not mandatory</u> for Inherited disorders

☐ Continued complete remission (CCR)

☐ CR achieved: Date achieved : ----------
yyyy - mm - dd

☐ Never in CR: Date assessed: ----------
yyyy - mm - dd

☐ Not evaluated

Last Contact Date for 100 day Assessment

If patient has died before this date, enter date of death, otherwise enter Date of HSCT + 100 DAYS APPROX.

Day 100 assessment : ----------
yyyy - mm - dd

Date of death (if before day 100): ----------
yyyy - mm - dd

Chronic GvHD at day 100 (Allografts)

Chronic Graft Versus Host Disease present between HSCT and 100 days or date of death

(allografts only)

☐ No *(never)*

☐ Yes: Date of diagnosis of cGvHD ----------
yyyy - mm - dd

Maximum extent <u>during this period</u>

☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score <u>during this period</u>

☐ Mild ☐ Moderate ☐ Severe ☐ Not calculated

Relapse/Progression

First Relapse or Progression after HSCT *(detected by any method*

☐ No:

☐ Yes: Date first seen ----------
yyyy - mm - dd

☐ Continuous progression since HSCT

Relapse of Leukaemias

*If Yes or Continuous **and** diagnosis is acute or chronic leukaemia, fill in the section below:*

Method of detection of the first relapse or progression after HSCT

Fill in only for acute and chronic **leukaemias**

Relapse/progression detected by **clinical/haematological** method:

☐ No: Date assessed ----------

☐ Yes: Date first seen ----------
yyyy - mm - dd

☐ Not evaluated

Relapse/progression detected by **cytogenetic** method:

☐ No: Date assessed ----------

☐ Yes: Date first seen ----------
yyyy - mm - dd

☐ Not evaluated

Relapse/progression detected by **molecular** method:

☐ No: Date assessed ----------

☐ Yes: Date first seen ----------
yyyy - mm - dd

☐ Not evaluated

Disease assessment at 100 days (All diseases)

Disease status when the patient was last seen before day 100 or date of death

(record the most recent status and date for each method, depending on the disease)

Was disease detected by clinical/haematological method when the patient was last assessed before day 100 or date of death

☐ No ☐ Yes

Last date assessed ----------
yyyy - mm - dd

☐ Not evaluated since HSCT was done

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

Disease Assessment at 100 days - Leukaemias

Was disease detected by cytogenetic/FISH method when the patient was last assessed before day 100 or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes:

Last date assessed ----------
yyyy - mm - dd

☐ Not evaluated since HSCT was done

Was disease detected by molecular method when the patient was last assessed before day 100 or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes:

Last date assessed ----------
yyyy - mm - dd

☐ Not evaluated since HSCT was done

Survival Status at 100 days – All diseases

Survival Status last contact date at 100 day assessment:

☐ Alive ☐ Dead

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

- ☐ Relapse or Progression/Persistent disease
- ☐ Secondary malignancy
- ☐ 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 .....

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

HSCT - Minimum Essential Data - A FOLLOW UP REPORT - ANNUAL

Disease

PRIMARY DISEASE DIAGNOSIS……

Centre Identification

EBMT Code (CIC): ---------- Contact person: ----------

Hospital: ---------- Unit: ---------- Email: ----------

Patient Data

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

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

Name of study / trial .....

Hospital Unique Patient Number/ Code: ----------

(Compulsory, registrations will not be accepted without this item)

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

Date of Last Contact

Date of last follow up or death: ----------
yyyy - mm - dd

Best response after HSCT (CLL & Myeloma only)

Best disease status (response) after transplant

(prior to any treatment modification in response to a post HSCT disease assessment)

☐ Continued complete remission (CCR)

☐ CR achieved: Date achieved : ----------
yyyy - mm - dd

☐ Never in CR: Date assessed: ----------
yyyy - mm - dd

☐ Previously reported

Complications after Transplant (Allografts)

If patient has had a previous allograft, fill in the following sections:

Acute Graft Versus Host Disease (Allografts only)

Maximum Grade:

☐ 0 (none) ☐ I ☐ II ☐ III ☐ IV ☐ Present but grade unknown ☐ Not evaluated

Date of onset _____
yyyy - mm - dd

Stage:

Skin	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Liver	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Lower GI tract	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Upper GI tract	☐ 0 (none)	☐ 1			
Other site affected	☐ No	☐ Yes			

Chronic Graft Versus Host Disease present during this period

☐ No *(never)*

Yes: ☐ First episode since last HSCT

Date of diagnosis of cGvHD: _____
yyyy - mm - dd

☐ Recurrence

Date first evidence of cGVHD during this period: _____
yyyy - mm - dd

☐ Continuous since last reported episode

Maximum exten during this period

☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score during this period

☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

☐ Resolved since last report *(currently absent)*

Late graft failure ☐ No ☐ Yes:

Secondary Malignancy

Did a secondary malignancy, lymphoproliferative or myeloproliferative disorder occur?

☐ No ☐ Yes:

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

Diagnosis: .....

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

Additional Disease Treatment including Cell Therapy

Was additional treatment given for the disease indication for transplant?

☐ No

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

-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 not a boost, please attach the Cell Infusion (CI) sheet on the last page, completing as many sections as episodes of cell infusion that took place during this interval, then continue below**

-Chemo / radiotherapy

Additional disease treatment given excluding cell infusion?

☐ No

☐ Yes: ☐ Prophylaxis / preemptive/ preventive *(planned before the transplant took place)*

☐ For relapse / progression or persistent disease *(not planned)*

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

Chemo/drug

☐ No Tick here if continuous from last follow up report

☐ 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

Relapse or Progression after HSCT

First Relapse or Progression after HSCT *(detected by any method)*

☐ No:

☐ Yes: Date first seen .....
yyyy - mm - dd

☐ Continuous progression since HSCT

Relapse of Leukaemias

*If Yes or Continuous **and** diagnosis is acute or chronic leukaemia, fill in the section below:*

Method of detection of the first relapse or progression after HSCT

Fill in only for acute and chronic **leukaemias**

Relapse/progression detected by **clinical/haematological** method:

☐ No: Date assessed _____

☐ Yes: Date first seen _____ *yyyy - mm - dd*

☐ Not evaluated

Relapse/progression detected by **cytogenetic** method:

☐ No: Date assessed _____

☐ Yes: Date first seen _____ *yyyy - mm - dd*

☐ Not evaluated

Relapse/progression detected by **molecular** method:

☐ No: Date assessed _____

☐ Yes: Date first seen _____ *yyyy - mm - dd*

☐ Not evaluated

Last disease status – All diseases

Disease status when the patient was last assessed? (or date of death)

(record the most recent status and date for each method, depending on the disease)

Was disease detected by clinical/haematological method when the patient was last assessed or date of death?

☐ No ☐ Yes

Last date assessed _____ *yyyy - mm - dd*

☐ Not evaluated since HSCT was done

Last disease assessment - Leukaemias

Was disease detected by cytogenetic/FISH method when the patient was last assessed or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes

Last date assessed _____ *yyyy - mm - dd*

☐ Not evaluated during this period

Was disease detected by molecular method when the patient was last assessed or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes

Last date assessed _____ *yyyy - mm - dd*

☐ Not evaluated during this period

Pregnancy after HSCT

Has patient or partner become pregnant after this transplant?

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

Survival Status

☐ Alive ☐ Dead

Check here if patient lost to follow up ☐

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

- ☐ Relapse or Progression/Persistent disease
- ☐ Secondary malignancy
- ☐ 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: _____

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

HSCT - Minimum Essential Data - A
FOLLOW UP REPORT - ANNUAL

CELL INFUSION (CI) SHEET

CELL INFUSION

Date of first infusion: _____
yyyy - mm - dd

Disease status before this CI ☐ CR ☐ Not in CR ☐ Not evaluated

Cell infusion (CI) regimen *(not HSCT or autologous stem cell re-infusion)*

Source of cell(s): *(check all that apply)* ☐ Allo ☐ Auto

Type of cell(s): *(check all that apply)*

☐ Lymphocyte *(DLI)* ☐ Mesenchymal ☐ Fibroblasts ☐ Dendritic cells
☐ NK cells ☐ Regulatory T-cells ☐ Gamma/delta cells ☐ Other, specify _____

Chronological number of CI for this patient _____

Indication: *(check all that apply)*

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

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: ☐ 0 (none) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Present but grade unknown

CELL INFUSION

Date of first infusion: _____
yyyy - mm - dd

Disease status before this CI ☐ CR ☐ Not in CR ☐ Not evaluated

Cell infusion (CI) regimen *(not HSCT or autologous stem cell re-infusion)*

Source of cell(s): *(check all that apply)* ☐ Allo ☐ Auto

Type of cell(s): *(check all that apply)*

☐ Lymphocyte *(DLI)* ☐ Mesenchymal ☐ Fibroblasts ☐ Dendritic cells
☐ NK cells ☐ Regulatory T-cells ☐ Gamma/delta cells ☐ Other, specify _____

Chronological number of CI for this patient _____

Indication: *(check all that apply)*

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

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: ☐ 0 (none) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Present but grade unknown