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

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

FOR ALL DISEASES	# MED-B AUTOGRAFT REGISTRATION – DAY 0

PATIENT

PERFORMANCE SCORE

Type of score used ☐ Karnofsky ☐ Lansky

SCORE *(For more detailed description, see manual)*

☐ 100	Normal, NED	Normal, NED
☐ 90	Normal activity; minor signs and symptoms of disease	Minor restrictions in physically strenuous activity
☐ 80	Normal with effort	Active, but tires more quickly
☐ 70	Cares for self, unable to perform normal activity	Both greater restriction of and less time spent in play activity
☐ 60	Requires occasional assistance	Up and around, but minimal active play; keeps busy with quieter activities
☐ 50	Requires considerable assistance	Gets dressed but lies around much of the day, no active play but able to participate in all quiet play and activities
☐ 40	Requires special care; disabled	Mostly in bed; participates in quiet activities
☐ 30	Severely disabled	In bed; needs assistance even for quiet play
☐ 20	Very sick	Often sleeping; play entirely limited to very passive activities

☐ Not evaluated

☐ Unknown

PATIENT 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 as listed below at time of patient assessment prior to the preparative regimen? ☐ No ☐ Yes, indicate each comorbidity below

Comorbidity	Definitions	No	Yes	Not evaluated
Solid tumour, previously present	Treated at any time point in the patient's past history, excluding non-melanoma skin cancer Indicate type ……	☐	☐	☐
Inflammatory bowel disease INBWDIS	Crohn's disease or ulcerative colitis	☐	☐	☐
Rheumatologic	SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica	☐	☐	☐
Infection INFECPRE	Requiring continuation of antimicrobial treatment after day 0	☐	☐	☐
Diabetes	Requiring treatment with insulin or oral hypoglycaemics but not diet alone	☐	☐	☐
Renal: moderate/severe KIDNEYCO	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 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 VALVE	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 PEPTICU	Requiring treatment	☐	☐	☐
Psychiatric disturbance	Depression or anxiety requiring psychiatric consultation or treatment	☐	☐	☐

Specify other additional ***major*** clinical abnormalities not listed above and present prior to the preparative regimen:

……

COLLECTION OF CELL PRODUCT ACTUALLY REINFUSED

SOURCE OF STEM CELLS

Check all that apply:

☐ Bone marrow: Total number of collections: .....

☐ Peripheral blood: Total number of mobilisation courses: ..... ☐ No mobilisation
(Steady state; e.g. CML at diagnosis)

☐ Cord blood

☐ Other, specify .....

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

COLLECTION

BONE MARROW OR UNMOBILISED PERIPHERAL BLOOD

Date of 1st collection .... - .... - ....
yyyy mm dd

PERIPHERAL BLOOD MOBILISATION

List all drugs: chemotherapy, growth factors, antibodies, etc.

Date of 1st aphaeresis after this mobilisation	Number of this mobilisation	Drug name	Drug name	Drug name
.... - .... - .... *yyyy mm dd*	.....	.....	.....	.....
		.....	.....	.....
.... - .... - .... *yyyy mm dd*	..... .	.....	.....	.....
		.....	.....	.....
.... - .... - .... *yyyy mm dd*	.....	.....	.....	.....
		.....	.....	.....

HSCT

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 ☐ N/A

If >1, was last HSCT performed at another institution? ☐ No ☐ Yes: CIC if known .....

Name of the institution ……

City ……

⇨ If >1, please submit a **MED-A annual follow up** 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).

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

HSCT part of a multiple sequential graft program:

☐ No
☐ Yes:
☐ Specify type of graft programme:_____
☐ Yes: Graft number in the program _____ out of _____ total number of HSCTs in the program

☐ Unknown

Reason for this transplant ☐ Relapse/progression after previous HSCT
☐ Graft failure after allo BMT
☐ Other, specify .....

EX VIVO GRAFT MANIPULATION

MANIPULATION

☐ No
☐ Yes: Negative selection ☐ No
☐ Yes: Monoclonal antibodies ± complement
☐ No ☐ Yes, specify: ..... , ..., ... ☐ Unknown
Other, specify .....
☐ Unknown

Positive selection ☐ No
☐ Yes: Monoclonal antibodies
☐ No ☐ Yes: ☐ CD 34+ ☐ CD 38- ☐ DR –
☐ Thy 1+ ☐ Lin - ☐ Other: .....
☐ Unknown

Long term culture ☐ No ☐ Yes ☐ Unknown
Other: .....

☐ Unknown

EXPANSION

☐ No ☐ Yes: Method, specify ……. ☐ Unknown

GENE MANIPULATION
(gene transfer/transduction)

☐ No ☐ Yes ☐ Unknown

PREPARATIVE TREATMENT **AND** INFUSION

PREPARATIVE TREATMENT (CONDITIONING)

Drugs ☐ No ☐ Yes ☐ Unknown
(include any active agent be it chemo, monoclonal antibody, polyclonal antibody, serotherapy, etc.)

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

Specification and dose of the preparative regimen

TOTAL PRESCRIBED CUMULATIVE DOSE*

Multiply daily dose in mg/kg or mg/m² by the number of days; e.g. Bu*sulfan given 4mg/kg daily for 4 days, total dose to report is 16mg/kg. NOTE: ONLY AGENTS GIVEN **BEFORE** THE DATE OF THE 1ST CELL INFUSION (DAY 0) SHOULD BE LISTED HERE*

DRUG (given before day 0)	DOSE	UNITS		Area under the curve (AUC)
☐ Ara-C *(cytarabine)*		☐ mg/m²	☐ mg/Kg	
☐ ALG, ATG 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 *(radiolabelled MoAB)*		☐ mCi	☐ MBq	
☐ CCNU		☐ mg/m²	☐ mg/Kg	
☐ Campath *(antiCD52)*		☐ 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	

TBI ☐ No ☐ Yes ☐ Unknown

Total dose (Gy): .... - ..... Number of fractions .... over .... radiation days

TLI / TNI / TAI ☐ No ☐ Yes: Total dose (Gy): .... - ..... ☐ Unknown

Local radiotherapy ☐ No ☐ Yes ☐ Unknown

CELLS COLLECTED AND INFUSED

(complete the whole table in case of graft manipulation)

	Bone Marrow	Peripheral Blood	Cord Blood
Evaluated <u>before</u> manipulation and cryopreservation: - Total nb. of nucleated cells (/kg) - CD 34+ (cells/kg)	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - .... x 10^6
Evaluated <u>after</u> manipulation and <u>before</u> cryopreservation: - Total nb. of nucleated cells (/kg) - CD 34+ (cells/kg)	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - ....x 10^6
Cells actually infused (after thawing (if thawing) and manipulation (if manipulation)): - Total nb. of nucleated cells (/kg) - CD 34+ (cells/kg)	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - .... x 10^6	.... - .... x 10^8 .... - ....x 10^6

(kg of recipient body weight)*

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)*:

(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

....

FOR ALL DISEASES	**MED-B AUTOGRAFT REGISTRATION – DAY 100**

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

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

Hospital Unique Patient Number .....

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

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

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

RECOVERY

Absolute neutrophil count (ANC) recovery *(Neutrophils ≥0.5X10⁹ /L)*
☐ No: Date of last assessment: ..... - ..... - .....
yyyy mm dd
☐ Yes: Date of ANC recovery: ..... - ..... - ..... *(first of 3 consecutive values after 7 days without transfusion)*
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

Platelets **≥50** x 10^9/l*; (first of 3 consecutive values after 7 days without transfusion)*
☐ No
☐ Yes: Date Platelets ≥ 50 x 10^9/l ..... - ..... - .....
yyyy mm dd
☐ Never below this level
☐ Date unknown: patient discharged before levels reached
☐ Date unknown: out-patient
☐ Unknown

Date last platelet transfusion:..... - .... - .... ☐ Not applicable: not transfused
yyyy mm dd

Early graft loss *(Engraftment followed by loss of graft within the first 100 days)*
☐ No ☐ Unknown
☐ Yes: date of graft failure .... - .... - ....
yyyy mm dd

TREATMENT FOR FAILURE
(If engraftment failure)

☐ No
☐ Growth factors
☐ Subsequent transplant *(please complete a new transplant form)*:

Date: .... - .... - .... ☐ AUTOgraft *(must have prior conditioning)*
yyyy mm dd ☐ ALLOgraft

☐ Autologous PBSC re-infusion/boost *(no preparative treatment or conditioning)*
☐ Autologous BM re-infusion/boost *(no preparative treatment or conditioning)*
☐ Other: .....

TREATMENT DURING THE IMMEDIATE POST-TRANSPLANT PERIOD

GROWTH FACTORS *(CYTOKINES)*
(excluding growth factors administered for engraftment failure)

☐ No

☐ Yes, specify ..... Date started: .... - .... - ....
yyyy mm dd

☐ Unknown

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 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 ....

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

Chronological number of the cell infusion episode for this patient .....

Indication: *(check all that apply)*

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

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

ADDITIONAL DISEASE TREATMENT

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

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

Chemo/drug
☐ No
☐ Yes:
☐ Anti-lymphocyte antibodies
☐ Azacytidine
☐ Azathioprine
☐ Bortezomib (Velcade)
☐ Cop-I
☐ Corticosteroids
☐ Crenolanib
☐ Cyclophosphamide
☐ Dasatinib (Sprycel)
☐ Decitabine
☐ Eculizumab (Soliris)
☐ Imatinib mesylate (Gleevec, Glivec)
☐ Interferon α
☐ Interferon β
☐ Kepivance (KGF, palif ermin)
☐ Lenalidomide (Revlimid)
☐ Midostaurin
☐ Mitoxantrone
☐ Nilotinib (Tasigna)
☐ Panobinosta
☐ Quizartinib
☐ Rituximab (Rituxan, mabthera)
☐ Sorafenib
☐ Thalidomide
☐ Velafermin (FGF)

☐ Other HDAC inhibitor: ……
☐ Other TKI inhibitor: ……

☐ Other drug/chemotherapy, specify ……. Intrathecal: ☐ No ☐ Yes

Radiotherapy ☐ No ☐ Yes: ☐ Unknown
TLI: ☐ No ☐ Yes

Other type ☐ No ☐ Yes, specify …….. ☐ Unknown

COMPLICATIONS WITHIN THE FIRST 100 DAYS.

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.*
Bacteraemia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF		
Septic shock		
ARDS		
Multiorgan failure due to infection		
ENDORGAN DISEASES		
Pneumonia		
Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		

Retinitis		
Other: ..... VOTINCOM		
		yyyy mm dd

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

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

NON INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

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

yyyy *mm* *dd*

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): ..... - ..... - .....

FIRST RELAPSE OF PROGRESSION

☐ No

☐ Yes; date diagnosed: ..... - ..... - .....
yyyy mm dd

FOR LEUKAEMIAS ONLY, IF RELAPSE OR PROGRESSION IS YES, FILL IN METHOD DETAILS:

Method of detection		Site
Clinical/haematological relapse or progression	☐ No: Date assessed ..... - ..... - ..... yyyy mm dd	
	☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd	☐ marrow – blood ☐ extramedullary
	☐ Not evaluated	
Cytogenetic relapse or progression	☐ No: Date assessed ..... - ..... - ..... yyyy mm dd	
	☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd	☐ marrow – blood ☐ extramedullary
	☐ Not evaluated	
Molecular relapse or progression	☐ No: Date assessed ..... - ..... - ..... yyyy mm dd	
	☐ Yes: Date first seen ..... - ..... - ..... yyyy mm dd	☐ marrow – blood ☐ extramedullary
	☐ Not evaluated	

☐ Continuous progression since transplant

☐ Unknown

DISEASE STATUS AT 100 DAYS *(record the most recent status and date for each method of assessment, depending on the disease)*

Method	Disease detected	
Clinical/haematological	☐ No ☐ Yes	
DISCLI DISCLID	Last date evaluated ..... - ..... - ..... yyyy mm dd	☐ Not evaluated
FILL IN ONLY FOR ACUTE AND CHRONIC LEUKAEMIAS		
Cytogenetic/FISH	☐ No ☐ Yes: Considered disease relapse/progression	☐ No ☐ Yes
	Last date assessed ..... - ..... - ..... yyyy mm dd	☐ Not evaluated
Molecular	☐ No ☐ Yes: Considered disease relapse/progression	☐ No ☐ Yes
DISMOL DISMOLDR DISMOLD	Last date assessed ..... - ..... - ..... yyyy mm dd	☐ Not evaluated

SURVIVAL STATUS AT 100 DAYS

☐ Alive
☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

SCORE *(For more detailed description, see manual)*

☐ 100	Normal, NED	Normal, NED
☐ 90	Normal activity; minor signs and symptoms of disease	Minor restrictions in physically strenuous activity
☐ 80	Normal with effort	Active, but tires more quickly
☐ 70	Cares for self, unable to perform normal activity	Both greater restriction of and less time spent in play activity
☐ 60	Requires occasional assistance	Up and around, but minimal active play; keeps busy with quieter activities
☐ 50	Requires considerable assistance	Gets dressed but lies around much of the day, no active play but able to participate in all quiet play and activities
☐ 40	Requires special care; disabled	Mostly in bed; participates in quiet activities
☐ 30	Severely disabled	In bed; needs assistance even for quiet play
☐ 20	Very sick	Often sleeping; play entirely limited to very passive activities

☐ Not evaluated

MAIN CAUSE OF DEATH *(if dead)*

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

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

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

COMMENTS .....

IDENTIFICATION & SIGNATURE

.....