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Author	|	Annelot van Amerongen
Authorised By	|	Annelot van Amerongen
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ALLOGENEIC HAEMATOPOIETIC CELL TRANSPLANTATION (HCT)
Day 0

Date of this HCT: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*
(or planned date of HCT if patient died before treatment)

Center where treatment took place (CIC): _ _ _ _

Survival status at HCT:

☐ Alive

☐ Died after conditioning but before HCT

Indication diagnosis for this HCT:_____
(make sure the indication diagnosis has been registered first, using the relevant diagnosis form)

Chronological number of this treatment: _____
(*all types of treatments for this patient, e.g. HCT, CT, IST*)

Chronological number of this HCT: _____
(*all HCTs this patient received in the past*)

Chronological number of this allogeneic HCT: _____
(*all allogeneic HCTs this patient received in the past*)

Complete this section only if the chronological number of the treatment is >1 for this patient.

If > 1:

Reason for this HCT:

☐ Indication diagnosis

☐ Relapse/progression after previous treatment (HCT/CT)

☐ Complication after previous treatment (HCT/CT)

☐ Primary graft failure

☐ Secondary graft failure

☐ Secondary malignancy

☐ Other; specify: _____

Date of the last treatment before this one: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Type of the last treatment before this one:

☐ Autologous HCT

☐ Allogeneic HCT

☐ Cellular therapy

Was the last treatment performed at another institution?

☐ No

☐ Yes: CIC (if known): _____

Name of institution: _____

City: _____

Submit the relevant follow-up form for the previous HCT/CT using the follow up assessment date before this HCT. It is required to capture relapse data and other events between transplants/cellular therapies.

DONOR & GRAFT INFORMATION

Is this HCT part of a multiple (sequential) graft program/protocol?

☐ No

☐ Yes: **Chronological number of this HCT as part of multiple (sequential) graft program/protocol for this patient:** _____

If this is the first allogeneic HCT for this patient, complete the patient HLA section in the database.

Multiple donors *(including multiple CB units)***:**

☐ No

☐ Yes: Number of donors: _____

DONOR & GRAFT INFORMATION
--- Donor __ (number)---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

Did the donor consent to having their data in the EBMT registry?

☐ No (complete only fields marked with '*' on pages 3-5)

☐ Yes

Date of birth: _ _ _ _* / _ _ / _ _ *(YYYY/MM/DD)*

(year of birth is a mandatory field)

***Age at time of donation:** _____ **years**
(optional)

***Age in months:** ____
(optional, if the donor was younger than 1 year)

***Sex** *(at birth)*:**

☐ Male

☐ Female

Donor Identification:

Donor ID given by the treating centre *(mandatory)*: _____

Global registration identifier for donors (GRID): _____

ION code of the Donor Registry or Cord Blood Bank *(mandatory)*: _____

EuroCord code for the Cord Blood Bank *(if applicable)*: _____

Name of Donor Registry or Cord Blood Bank: _____

Donor ID given by the Donor Registry or Cord Blood Bank: _____

Patient ID given by the Donor Registry or Cord Blood Bank: _____

***Donor EBV status:**	***Donor CMV status:**
☐ Negative	☐ Negative
☐ Positive	☐ Positive
☐ Not evaluated	☐ Not evaluated
☐ Unknown	☐ Unknown

Is donor an HbS trait carrier? *(for Sickle Cell Disease only)*

☐ No

☐ Yes

Did this donor provide more than one stem cell product:

☐ No

☐ Yes: Number of different stem cell products from this donor: _____

(If 2 products e.g. BM and PM, complete 'Donor 1 - Product Number 1 ***and*** *2' on page 3)*

DONOR & GRAFT INFORMATION
--- Donor __(number) continued ---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

*Donor __(number) - Product Number 1

If more than one stem cell product , this is the first product collected from this donor.

***Source of stem cells:**
(select only one)

- ☐ Bone Marrow
- ☐ Peripheral Blood
- ☐ Cord Blood
- ☐ Other; specify: _____

***Graft manipulation *ex-vivo* including T-cell depletion:**
(other than for RBC removal or volume reduction)

- ☐ No
- ☐ *Yes:
  - ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag".)*
  - ☐ T-cell receptor αβ depletion
  - ☐ B-cell depletion (CD19+) by MoAB
  - ☐ NK cell depletion by MoAB
  - ☐ CD34+ enrichment
  - ☐ Genetic manipulation
  - ☐ Other; specify: _____

*Donor __(number) - Product Number 2

If more than one stem cell product , this is the second one infused from this donor.

***Source of stem cells:**
(select only one)

- ☐ Bone Marrow:
- ☐ Peripheral Blood:
- ☐ Cord Blood
- ☐ Other; specify: _____

***Graft manipulation *ex-vivo* including T-cell depletion:**
(other than for RBC removal or volume reduction)

- ☐ No
- ☐ *Yes:
  - ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag".)*
  - ☐ T-cell receptor αβ depletion
  - ☐ B-cell depletion (CD19+) by MoAB
  - ☐ NK cell depletion by MoAB
  - ☐ CD34+ enrichment
  - ☐ Genetic manipulation
  - ☐ Other; specify: _____

DONOR & GRAFT INFORMATION
--- Donor __(number) continued ---

Copy and fill-in this section as many times as necessary, marking if it refers to Donor 1, 2, etc.

***HLA match type and patient/donor relation:**

☐ *Related donor, type:

☐ *Match (both haplotypes matched)

☐ *Mismatch:

***Degree of matching:** ☐ One haplotype mismatch

☐ *Partial haplotype mismatch, number of mismatched HLA alleles:
(select only one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

***Mismatch at locus:** *(check all that apply)*

☐ A ☐ DRB1
☐ B ☐ DQB1
☐ C ☐ DPB1

***Both haplotypes confirmed by family studies?** *(for both matched and mismatched related donors)*

☐ No
☐ Yes
☐ Unknown

Relationship to patient *(for both matched and mismatched related donors)*:

☐ Syngeneic (monozygotic twin) (*option only for matched related donors*)
☐ Sibling *(may include non-monozygotic twin)*
☐ Other related:
☐ Parents
☐ Child
☐ Aunt/Uncle
☐ Cousin
☐ Grand Parents
☐ Other; specify: _____

☐ *Unrelated donor:

***Degree of HLA matching:**	**HLA-DPB1 matching:**
☐ Full match (10/10)	☐ Match ☐ At least 1 mismatch ☐ Not typed
☐ Single HLA mismatch (9/10)	***Mismatch at locus:** *(check all that apply)* ☐ A ☐ B ☐ C ☐ DRB1 ☐ DQB1 ☐ DPB1
☐ >=2 HLA mismatches (<9/10)	

Please enter the LABORATORY RESULTS WITH HLA TYPING into the database for all the donors

ADDITIONAL ASSESSMENTS
(All diagnoses)

Are there Donor-Specific Antibodies (DSA) against HLA?

☐ No

☐ Yes: **HLA loci the DSA are directed against:** ☐ A ☐ B ☐ C ☐ DRB1 ☐ DQB1 ☐ DPB1

Did the patient have desensibilisation therapy? ☐ No
(Haemoglobinopathies only) ☐ Yes; specify: _____

Are the DSA red cell antibodies? ☐ No
(Haemoglobinopathies only) ☐ Yes: **Are they cross-reacting with the red cells of the donor?** ☐ No ☐ Yes

☐ Not evaluated

☐ Unknown

PATIENT SEROLOGICAL STATUS
(All diagnoses)

Patient EBV status:
☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

Patient CMV status:
☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

PREPARATIVE REGIMEN
(All Diagnoses)

Preparative (conditioning) regimen given?

☐ No *(Primary Immunodeficiency Disorders only)*

☐ Yes

Drugs given? *(any active agent, including chemotherapy, monoclonal antibody, polyclonal antibody, serotherapy, etc.)*

☐ No

☐ Yes (provide details in the table on pages 7-8)

What type of conditioning regimen was used?

☐ Reduced intensity conditioning (RIC)

☐ Myeloablative conditioning (MAC)

PREPARATIVE REGIMEN continued

Specification and dose of the preparative regimen:
(Report the total prescribed cumulative dose as per protocol. Multiply daily dose by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg.)

Chemotherapy	Dose	Units
☐ Bendamustine	_____	☐ mg/m² ☐ mg/kg
☐ Bleomycin	_____	☐ mg/m² ☐ mg/kg
☐ Busulfan Route of administration: ☐ Oral ☐ IV ☐ Both Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carboplatin Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carmustine	_____	☐ mg/m² ☐ mg/kg
☐ Cisplatin	_____	☐ mg/m² ☐ mg/kg
☐ Clofarabine	_____	☐ mg/m² ☐ mg/kg
Corticosteroids:		
☐ Beclometasone	_____	☐ mg/m² ☐ mg/kg
☐ Budesonide	_____	☐ mg/m² ☐ mg/kg
☐ Dexamethasone	_____	☐ mg/m² ☐ mg/kg
☐ Methylprednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Prednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Cyclophosphamide	_____	☐ mg/m² ☐ mg/kg
☐ Cytarabine	_____	☐ mg/m² ☐ mg/kg
☐ Daunorubicin	_____	☐ mg/m² ☐ mg/kg
☐ Doxorubicin	_____	☐ mg/m² ☐ mg/kg
☐ Epirubicin	_____	☐ mg/m² ☐ mg/kg
☐ Etoposide	_____	☐ mg/m² ☐ mg/kg
☐ Fludarabine	_____	☐ mg/m² ☐ mg/kg
☐ Gemtuzumab ozogamicin	_____	☐ mg/m² ☐ mg/kg
☐ Ibritumomab tiuxetan	_____	☐ mCi ☐ MBq
☐ Idarubicin	_____	☐ mg/m² ☐ mg/kg

PREPARATIVE REGIMEN continued

Specification and dose of the preparative regimen:

(Report the total prescribed cumulative dose as per protocol. Multiply daily dose by the number of days; e.g. for Busulfan given 4mg/kg daily for 4days, total dose to report is 16mg/kg.)

Chemotherapy	Dose	Units
☐ Ifosfamide	_____	☐ mg/m^2 ☐ mg/kg
☐ Imatinib	_____	☐ mg/m^2 ☐ mg/kg
☐ Lomustine	_____	☐ mg/m^2 ☐ mg/kg
☐ Melphalan	_____	☐ mg/m^2 ☐ mg/kg
☐ Mitoxantrone	_____	☐ mg/m^2 ☐ mg/kg
☐ Paclitaxel	_____	☐ mg/m^2 ☐ mg/kg
☐ Rituximab	_____	☐ mg/m^2 ☐ mg/kg
☐ Teniposide	_____	☐ mg/m^2 ☐ mg/kg
☐ Thiotepa	_____	☐ mg/m^2 ☐ mg/kg
☐ Tositumomab	_____	☐ mCi ☐ MBq
☐ Treosulfan	_____	☐ mg/m^2 ☐ mg/kg
☐ Other; specify*: _____	_____	☐ mg/m^2 ☐ mg/kg ☐ mCi ☐ MBq

*Please consult the **LIST OF CHEMOTHERAPY DRUGS/AGENTS AND REGIMENS** on the EBMT website for drugs/regimens names

Total body irradiation (TBI):

☐ No

☐ Yes; Total prescribed radiation dose as per protocol: _____ Gy

Number of fractions: _____

Number of radiation days: _____

GvHD PROPHYLAXIS

GvHD prophylaxis or preventive treatment:

☐ No

☐ Yes: ☐ Drugs *(report in the table below)*

☐ Extracorporeal photopheresis (ECP)

☐ Other; specify: _____

☐ Abatacept
☐ Alemtuzumab
☐ Anti-Thymocyte Globulin|Anti-Lymphocyte Globulin Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____
☐ Basiliximab
Corticosteroids: ☐ Beclometasone ☐ Budesonide ☐ Dexamethasone ☐ Methylprednisolone ☐ Prednisolone
☐ Cyclophosphamide
☐ Cyclosporine
☐ Etanercept
☐ Everolimus
☐ Infliximab
☐ Methotrexate
☐ Mycophenolate mofetil
☐ Ruxolitinib
☐ Sirolimus
☐ Tacrolimus
☐ Other agent (in vivo); specify*: _____

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