CIC:	Hospital UPN:	HSCT Dat	e	·	
			уууу	mm	dd
Patient Number in El	BMT database (if known):				

DAY 0

MED-B GENERAL INFORMATION

	TEAM	
EBMT Centre Identification Code (CIC)		
Hospital	Unit	
Contact person:		
e-mail		
Date of this report mm do		
STUDY/TRIAL		
Patient following national / international study / trial		☐ Yes ☐ Unknown
	PATIENT	
Unique Identification Code (UIC)	(to be ente	ered only if patient previously reported)
Hospital Unique <u>Patient</u> Number or Code (UPI Compulsory, registrations will not be accepted without All transplants performed in the same patient must be rethe patient and <u>not</u> to the transplant.	this item.	ntification number or code as this belongs to
Initials(first name(s)	- surname(s))	
Date of birth do	Sex:	☐ Male ☐ Female
ABO Group	Rh factor:	☐ Present ☐ Not evaluated
	DISEASE	
Date of diagnosis :	dd	
PRIMARY DISEASE DIAGNOSIS (CHECK THE DIS	EASE FOR WHICH THIS TRANSPLANT V	VAS PERFORMED)
☐ Primary Acute Leukaemia ☐ Acute Myelogenous Leukaemia (AML) &	☐ Myeloma /Plasma cell diso☐ Solid Tumour	
related Precursor Neoplasms	_	Autoimmune disease
☐ Precursor Lymphoid Neoplasms (old ALL) ☐ Therapy related myeloid neoplasms (old	Myelodysplastic syndrome Myeloproliferative neoplas	
Secondary Acute Leukaemia) Chronic Leukaemia	☐ MDS	☐ Multiple Sclerosis
☐ Chronic Leukaernia ☐ Chronic Myeloid Leukaemia (CML) ☐ Chronic Lymphocytic Leukaemia (CLL)	☐ MDS/MPN ☐ Myeloproliferative neopla	☐ Systemic Lupus ☐ Systemic Sclerosis
☐ Lymphoma	Bone marrow failure includ	ing Haemoglobinopathy
□ Non Hodgkin□ Hodgkin's Disease	Aplastic anaemia Inherited disorders	
	□ Primary immune deficier□ Metabolic disorders	ncies
☐ Other diagnosis, specify:		

CIC:	Hospital UPN:	HSCT Date		
		уууу	mm	dd
Patient Number in	FRMT database (if known):			

DAY 0

MED-B

BONE MARROW FAILURE SYNDROME

(INCLUDING APLASTIC ANAEMIA)

INITIAL DIAGNOSIS

2) IMMUNOSUPPR	ISTER: ESSION THERAPY FOR PATIENTS THAT DO NOT PROCEED TO HSCT ESSION THERAPY AND HSCT FOR PATIENTS THAT RECEIVE IMMUNOSUPPRE ENTS THAT DO NOT RECEIVE PRIOR IMMUNOSUPPRESSION THERAPY	SSION AND THEN PROCEED TO HSCT
FOR IMMUNOSUPPRESS	ION THERAPY GIVEN POST-HSCT, PLEASE USE THE MED-B <u>FOLLOW UP</u> FORM	ı
SUBCLASSIFICA		
check one box in ea(ach column as necessary) TYPE:	ETIOLOGY:
☐ Acquired	☐ Aplastic anaemia	ETIOLOGT.
Acquired	□ Moderate □ Severe □ Very severe □ Pure red cell aplasia (non congenital PRCA) □ Paroxysmal nocturnal haemoglobinuria (PNH) Presentation: Haemolytic □ No □ Yes Aplastic □ No □ Yes Thrombotic □ No □ Yes Other, specify □ Pure white cell aplasia □ Amegakaryocytosis / thrombocytopaenia (non congenital) □ Other acquired cytopenic syndrome, specify:	☐ Idiopathic ☐ Secondary to hepatitis ☐ Secondary to toxin / other drug ☐ Other, specify
Genetic	☐ Fanconi: FANC complementation group	
	Other:	

CIC: Hospital	UPN:		. Н	SCT Date		dd
Patient Number in EBMT data	abase (if known):				УУУУ	mm dd
CYTOGENETICS						
Chromosome analysis						
If done: Technique used	☐ Conventiona	ı 🗆	FISH	□во	oth	
☐ Normal:	Number of meta					
☐ Abnormal:	Number of meta					
&	Number of meta	phases ex	camined:			
If abnorr	mal, indicate abno		found:	П	Absent	☐ Present
		risomy 8 risomy 3 (for Fanconi)		Absent	☐ Present
Other or	associated abno	rmalities (specify)			
☐ Not done or failed☐ Unknown						
Chromosomal breakage to (for <u>Fanconi</u>)	est 🔲 Negative	· 🗆	Positive	□ No	ot evaluated	
HAEMATOLOGICAL VAI	LUES	_	•			
Haemoglobin		ŭ	Not evalua		Untransfused	
Platelets			Not evalua	ated ப	Untransfused	I ☐ Transfused
Neutrophils Reticulocytes		10 ⁻ / L				
Reliculocytes		10 / L				
Ferritin		ng/ml				
COMPLICATIONS						
Haemorrhages		☐ Yes	☐ No	☐ Not e	valuated	☐ Unknown
Resistance to random pl	atelets	☐ Yes	□ No	☐ Not e	valuated	☐ Unknown
Systemic infection		☐ Yes	□No	☐ Not e	valuated	Unknown
PNH TESTS						
(To be filled in only for Aplast	ic anaemia or PNH	at diagnosi	s)			
Date of PNH test		 dd				
PNH diagnostics by flow	cytometry ☐ Clo	one absen	t			
		one preser t evaluate		ize of the P	NH clone in %	% :
Flow cytometry assessm Granulocytes Other, specify	☐ RBC		☐ Both			
PNH diagnostics by othe (if type of test unknown, wri				☐ CI	one absent one present ot done	
Clinical manifestations o	f PNH □ No	☐ Yes				

IMMUNOSUPPRESSIVE TREATMENT EPISODE							
WAS THE PATIENT TREATE (only if HSCT registration)	D BEFORE THE HS	SCT PROCEDURE	:?				
☐ No treatment (except transfus ☐ Yes	sions) <i>Please proceed to</i>	o "Status at HSCT" or	n page 8				
FIRST TREATMENT EPISOD (All types of registration)	E FOR THIS REGIST	<u> </u>					
Date treatment started							
ууу	ry mm dd						
SEQUENTIAL NUMBER OF THIS Count ALL treatment episodes incl	uding those that may he	ave been registered fo	or this patient with pre	evious data subl	missions		
IF 1 ST TREATMENT EPISODE I							
NUMBER OF TRANSFUSION RBC	S BEFORE THE 1ST TRE	ATMENT 20-50 units	□ >50 units	☐ None	☐ unknown		
NBC					unknown		
	RBC irradiated	□ No □ Y	es 🗖 unknov	wn			
Platelets	☐ <20 units	☐ 20-50 units	□ >50 units	■ None	☐ unknown		
	Platelets irradiate	d □ No □ Y	es unknow	wn			
OR IF PATIENT HAS BEEN TREAT	ED REFORE (Immun	osuppraesiva thara	ny or HSCT)				
REASON FOR THIS TREATM	 -		py 01 11001)				
☐ Failure of first line		elapse		☐ PR to pre	evious treatment		
☐ Secondary clonal		ther					
HAEMATOLOGICAL VALUE Haemoglobin	•	een collected within 3	B months prior to the t		used		
Platelets	10 ⁹ / L	■ Not evaluated	☐ Untransfused	I ☐ Transfu	ısed		
Neutrophils	10 ⁹ / L						
Reticulocytes	10 ⁹ / L						
Ferritin	ng/ml						

CIC:

Hospital UPN: Patient Number in EBMT database (if known):

HSCT Date..... - - - - dd

CIC:	Hosp	ital UPN:				HSCT [Oate			
Patient Numb	er in EBMT d	atabase (if	known):					уууу	mm	dd
Check at leas		Brand	Dose (mg/kg)	Start o	late		End da	ate	
						 mm	 dd		 mm	 dd
☐ Cycl	At Number in EBMT database (if known): ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date End date ATG Origin Brand Dose (mg/kg) Start date ATG Origin Brand Dose (m									
☐ Cycl	ophospham	ide								
□ Мус	ophenolate	mofetil								
☐ G-C	SF									
☐ Erytl	hropoietin									
☐ Cor	ticosteroid									
☐ And	rogens									
☐ Ritu	ximab (Mabt	hera)								
☐ Alen	ntuzumab (0	Campath)								
☐ Othe	er, specify									
RESPONSE	TO THIS IMN	MUNOSUPI	PRESSIVE TRE	ATME	NT EPIS	ODE				
□ No □ Yes:				RTED	BEFORE					
	Date of dia	gnosis o						☐ Not ap	oplicable	
			-:6:4:		-	mm	aa			
	FILL ONLY IF	PNH HAS	NOT BEEN REPOI							
			of PNH					⊔ Not a _l	oplicable	
	PNH dia	agnostics l	by flow cytome	-	☐ Clone	present		the PNH c	one in % :	·
	Flo		☐ Granulocyte	es	□R			☐ Both		
								☐ CI	one prese	
	Clinical	manifesta	tions of PNH		No	☐ Yes				

		•	tal UPN:					ate		 mm	 dd	
Patie	tient Number in EBMT database (if known):							УУУУ	111111	uu		
	_											
						N REPORTED			☐ Not ap	policable		
			olicable)			УУУУ		dd				
	Oth	ner, spec	ify									
HAS	S THE PAT	IENT UN	IDERGON	E AN A	DDITION	NAL EPISO	DE OF IN	MUNOS	UPPRESS	IVE TREA	TMENT	?
[☐ No additi	onal ther	ару ехсер	t transfu	isions:				ase proceed			
[⊐Yes					If only In	nmunosup	pressive tr	eatment, this	s is the end	of the for	m
		DITIO	SALAL II		1001		0	TDE 4 :	-	EDIOC	\D_	
	AL	אווטכ)NAL II	MMUI	NOSU	IPPRES	SIVE	IREA	IMENI	EPISC	DDE	
Date	e treatment	t started				 mm						
					уууу	111111	uu					
SEC	UENTIAL N	UMBER C	OF THIS TR	EATMEN	IT EPISC	DE:						
REA	SON FOR T	HIS TRE	ATMENT									
	Failure of fi	first line th	herapy	☐ Re	lapse				☐ PR to	previous t	reatment	
	Secondary	clonal di	isorder	☐ Oth	ner				. 🗖 Unkno	own		
	MATOLOGI		UES (Da	nta must l							. f	
	aemoglobin atelets				g/dL	☐ Not eva			ansfused ansfused			
						☐ Not eva	lluated	☐ Unti	ansiused	☐ Trans	siusea	
	eutrophils eticulocytes				10 / L							
110	sticulocytes				10 / L							
Fe	erritin				ng/ml							
		, , ,										
	lality: Cher	_	agent									
Che	ck at least on ATG O		Brand	Dose (mg/kg)	Start d	ate		End da	ite		
		☐ horse										
						уууу	mm	dd	УУУУ	mm	dd	
	☐ Cyclosp	oorin A										
	☐ Cycloph	hospham	ide									
	☐ Mycoph	nenolate i	mofetil									
	☐ G-CSF											
	☐ Erythrop	poietin										
	☐ Cortico	osteroid										
	☐ Androg	ens										
	Rituxim		hera)									
	☐ Alemtuz											

CIC: Hospital UPN:	HSCT Date
Patient Number in EBMT database (if known):	yyyy mm dd
☐ Other, specify	
RESPONSE TO THIS IMMUNOSUPPRESSIVE TREATMENT EPISOD	DE
☐ Complete remission ☐ Partial remission (transfusion and	growth factor independent)
☐ No response ☐ Progression ☐ Not evalued ☐ Other, specify	able
Date response evaluated	
yyyy mm dd	
SECONDARY CLONAL COMPLICATIONS	
□No	
☐ Yes: FILL ONLY IF MDS HAS NOT BEEN REPORTED BEFORE	
Date of diagnosis of MDS	1.
(if applicable) yyyy i	nm dd
MDS WHO classification	
FILL ONLY IF PNH HAS NOT BEEN REPORTED BEFORE	-
Date of diagnosis of PNH	•••
PNH diagnostics by flow cytometry	boont
	resent Size of the PNH clone in % :
□ Not eva	luated
Flow cytometry assessment done on:	
☐ Granulocytes ☐ RB ☐ Other, specify	-
,	
PNH diagnostics by other test, specify:(if type of test unknown, write "unknown" here)	□ Clone absent □ Clone present
(ii type of test unknown, write unknown here)	□ Not done
Clinical manifestations of PNH ☐ No [☐ Yes
FILL ONLY IF THIS DIAGNOSIS HAS NOT BEEN REPORTED B	EFORE .
Date of diagnosis of other	• • • • • • • • • • • • • • • • • • • •
(if applicable) yyyy i	nm dd
Other, specify	
HAS THE PATIENT UNDERGONE AN ADDITIONAL EPISODI	OF IMMUNOSUPPRESSIVE TREATMENT?
	gistration also, please proceed to "Status at HSCT" on page 8 unosuppressive treatment, this is the end of the form
☐Yes Photocopy or reprint the ADDITIONAL IMMUNOSUPPRESSIVE TR	

CIC: Hospi	ital UPN:		H	HSCT Date			
Patient Number in EBMT d	atabase (if known):				уууу	mm	dd
		СТЛТІ	S AT H	CCT			
Fill in only if this is an HSC					unly potiont		
				ioi lile is o	ппу рапети		
Date of HSCT			 <i>yyyy</i>	mm	dd		
			,,,,				
CYTOGENETICS							
If done: Technique used	☐ Conventiona	ı 🗆	FISH		Both		
☐ Normal:	Number of meta	ıphases ex	amined:				
☐ Abnormal:	Number of meta						
&	Number of meta	ıphases ex	amined:				
If abnormal, indicate abr				F	7 5		
trisomy 8 trisomy 3 <i>(for Fan</i>		☐ Absent☐ Absent		_	☐ Present ☐ Present		
-	ciated abnormalitie						
☐ Not done or failed	d						
Unknown							
HAEMATOLOGICAL V	ALUES		_	_		_	
Haemoglobin		_	Not evalu	_	☐ Untransfused	☐ Transfus	
Platelets			Not evalu	ated L	☐ Untransfused	☐ Transfus	ed
Neutrophils							
Reticulocytes		10 ⁹ / L					
Ferritin		ng/ml					
COMPLICATIONS							
Haemorrhages		☐ Yes	☐ No	☐ No	t evaluated	☐ Unknown	
Resistance to random	platelets	☐ Yes	□ No	☐ No	t evaluated	☐ Unknown	
Systemic infection		☐ Yes	□ No	□ No	t evaluated	☐ Unknown	
PNH TESTS							
(To be filled in only for Apla	astic anaemia or PNH	at diagnosis	s)				
	 yyyy mm	 dd					
PNH diagnostics by flo	,,,,	uu					
If done: ☐ Cone							
☐ Clone	e present	Size of t	he PNH clo	one in % _			
Assessed on:	☐ Granulocyte☐ Other, spec	-	RBC	☐ Both ☐ Not o	done		
PNH diagnostics by ot	her test		Clone abse	nt			
Specify test :				ent			
(ii type of test unkl	nown, write "unknown	riere) 🗀 l'	NOT GOLIE				
Clinical manifestations	□ No	☐ Yes					

CIC:	Hospital UF	PN:		HSCT [Date		
Patient Numb	ber in EBMT databa	se (if known):			уууу	mm	dd
		NS FROM DIAGNO those reported prior to		osuppre:	ssive treatment if ap	pplicable	
	RBC	□ <20 units	2 0-50	unite	□ >50 units	☐ None	□ unknown
	RBC irra	_ , ,	□ No	uiili3			□ diikilowii
	KBC III	dulated	L INO		es 🗖 ulikii	OWIT	
	Platelets	☐ <20 units	2 0-50	units	☐ >50 units	☐ None	☐ unknown
	Platelet	sirradiated	□ No	□Y	es □ unkn	own	
		FORMS	TO BE F	IIIF	D IN		
TYPE OF H	Ject	1 01 1110	10 02 1				
_							
☐ AUTO	graft, proceed to	Autograft day 0 for	m				
		graft, proceed to A			000		
If L Other	:	, contact the E	BMI Central	Registr	y Office for instru	ctions	

CIC:	Hospital UPN:	HSCT Date		
		уууу	mm	dd
Patient Number in	FRMT database (if known):			

MED-B DAY 100 BONE MARROW FAILURE SYNDROME

			(INCLUDING APLASTIC ANAEMIA)
Unique Identifica	ation Code (UIC	C)	(if known)
·	•		()
	уууу	mm dd	
Hospital Unique	Patient Number	er	
Initials:	(first	name(s)_surname(s)	
Date of birth			
	уууу і	mm dd	
Sex: (at birth)	☐ Male		☐ Female
Date of last HSC (if applicable)	CT for this patie	ent:	
	BEST DIS	SEASE RESPO	NSE AT 100 DAYS POST-HSCT
BEST RESPO	NSE AT 100 [DAYS AFTER HSCT	
☐ Complete r	emission \Box	Partial remission (trai	nsfusion and growth factor independent)
☐ No respons ☐ Other, spec	se	•	☐ Not evaluable
·	-	yyyy mm	
		FORMS T	O BE FILLED IN
TYPE OF TRAN	NSPLANT		
□ AUTOgraft	proceed to A	utograft day 100 forı	m
☐ ALLOgraft	or Syngeneic g	raft, proceed to Allo	graft day 100 form

CIC:	Hospital UPN:	 HSCT Date		
		уууу	mm	da
Patient Number in El	BMT database (if known):	 		

FOLLOW

MED-B

BONE MARROW FAILURE SYNDROME (INCLUDING APLASTIC ANAEMIA)

Unique Identificati	•	•			(if knowi	1)	
Date of this report	уууу	mm	dd	_	_	<u>_</u>	
Patient following r		-		☐ No	☐ Yes	☐ Unknown	
Name of study / tr							
Hospital Unique P							
Initials:	(firs	st name(s)_surr	name(s))				
Date of birth	 <i>yyyy</i>	mm dd					
Sex: (at birth)	☐ Male			☐ Female	Э		
Date of the most r	recent transp (if applicab		follow up	: <i>уууу</i>	 mm	 dd	
		PAT	IENT	LAST	SEEN		
DATE OF LAST	CONTACT	OR DEATH:	 <i>УУУУ</i>		 dd		
	Сс	mplication	s after	Transpla	ant (Allogra	afts)	
ANSWER IF PATIENT ACUTE GRAFT VE							
Maximum grade	☐ grade (O (Absent) 🔲 g	grade I 🛚	grade II	☐ grade III I	☐ grade IV ☐ Not evaluated	t
	If present:	☐ New onset	☐ Red	current	☐ Persistent		
	Reason:	☐ Tapering	☐ DLI		☐ Unexplaine	d	
					·	_	
	(if new or rec	of this episode: urrent)	уууу		dd	☐ Not applicable	
Stage: Skin Liver Lower G Upper G Other sit		□ 0 (none) □ 0 (none) □ 0 (none) □ 0 (none) □ No			II 🗆 IV		
Resolu □ No		es: Date of r	esolution:		 mm	 dd	

				 mm dd
Patient Number in EBMT database (if I	known):		уууу	mm da
ANSWER IF PATIENT HAS HAD AN ALLO				
Presence of cGvHD				
☐ Yes: ☐ First episode ☐ Recurrence				
Date of onset				
☐ Present continuously sin	ce last reported episode			
Maximum extent during this		tensive 🗖 L	Jnknown	
Maximum NIH score during	<u>this period</u> ☐ Mild ☐ Moderate	□ Severe	□ Not evalu	ated
Organs affected ☐ Ski		Liver Other, specify		Mouth Unknown
☐ Resolved: Date of resolu	ition:			
OTHER C	OMPLICATIONS	SINCE LA	ST REPORT	Г
PLEASE USE THE DOCUMENT "DEFINITION THESE ITEMS.	NS OF INFECTIOUS DISEASES A	ND COMPLICATIONS	AFTER STEM CELL TE	RANSPLANTATION" TO FILL
INFECTION RELATED COMPLIE	CATIONS			
INFECTION RELATED COMPLIC	CATIONS			
☐ No complications	Pat Use the list of after this ta	thogen If pathogens listed ble for guidance. wn" if necessary.	Provide different dat	Date tes for different episodes lication if applicable.
☐ No complications☐ Yes	Pat Use the list of after this ta Use " unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
☐ No complications ☐ Yes Type	Pat Use the list of after this ta Use " unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
☐ No complications ☐ Yes Type	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia /	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
□ No complications □ Yes Type Bacteremia / fungemia / viremia / □ SYSTEMIC SYMPTOMS OF INFECT	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / SYSTEMIC SYMPTOMS OF INFECT Septic shock	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
□ No complications □ Yes Type Bacteremia / fungemia / viremia / □ SYSTEMIC SYMPTOMS OF INFECT	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / SYSTEMIC SYMPTOMS OF INFECT Septic shock	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / SYSTEMIC SYMPTOMS OF INFECT Septic shock	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / SYSTEMIC SYMPTOMS OF INFECT Septic shock ARDS	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / SYSTEMIC SYMPTOMS OF INFECT Septic shock ARDS	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes
No complications Yes Type Bacteremia / fungemia / viremia / p Systemic Symptoms of Infect Septic shock ARDS Multiorgan failure due to infection	Pat Use the list of after this tai Use "unkno	f pathogens listed ble for guidance.	Provide different dat	tes for different episodes

CIC: Hosp	oital UPN:	HSCT Date			
Patient Number in EBMT of	database (if known):		уууу	mm	dd
Tatient Number in Edivit (uatabase (ii Kilowii)				
Ту	pe	Pathogen Use the list of pathogens listed after this table for guidance. Use "unknown" if necessary.	Provide different of the same con	Date dates for diffe nplication if ap	rent episodes oplicable.
Hepatitis					
CNS infection					
Gut infection					
Skin infection					
Cystitis					
Retinitis					
Other:	VOTINCOM				
			уууу r	nm dd	

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

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

CIC: Hospital UPN:	HSCT Date	ə		
Patient Number in EBMT database (if known):		уууу	mm	dd
NON INFECTION RELATED COMPLICATIONS	S			
☐ 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:				
	·	vvvv m	m dd	

EVENTS SINCE LAST FOLLOW UP	CIC: Hospital	UPN:	I	HSCT Date		
GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM Graft loss No Yes Not evaluated Overall chimaerism Full (donor \$95 %) Altologous reconstitution (recipient \$95 %) Aplasia Not evaluated Not evaluated Aplasia Aplasia Aplasia	Patient Number in EBMT data	base (if known):			ı	rim da
GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM Graft loss No Yes Not evaluated Overall chimaerism Full (donor \$95 %) Altologous reconstitution (recipient \$95 %) Aplasia Not evaluated Not evaluated Aplasia Aplasia Aplasia						
GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM Graft loss No Yes Not evaluated Overall chimaerism Full (donor \$95 %) Altologous reconstitution (recipient \$95 %) Aplasia Not evaluated Not evaluated Aplasia Aplasia Aplasia						
GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM Graft loss No Yes Not evaluated Overall chimaerism Full (donor \$95 %) Altologous reconstitution (recipient \$95 %) Aplasia Not evaluated Not evaluated Aplasia Aplasia Aplasia		EVENITO CINI	CEIACT			
Graft loss No		EVENTS SIN	CE LAST	FOLLOW UP		
Graft loss No	05.155.40050015115.41	II				
No	GRAFT ASSESSMENT A	ND HAEMOPOIETIC C	HIMAERISM			
Overall chimaerism ☐ Ruil (donor ≥95 %) ☐ Mixed (partial) ☐ Autologous reconstitution (recipient ≥95 %) ☐ Aplasia INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS. SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE. COPY THIS TABLE AS MANY TIMES AS NECESSARY. Identification of donor or Cords which test was performed cells Cell type on which test was Donor performed cells ☐ Test used ☐ DATE of test ☐ Mixed (partial) ☐ Test used ☐ FISH ☐ Mixed (partial) ☐ Test used ☐ Test used ☐ Test used ☐ FISH ☐ Mixed (partial) ☐ Test used ☐ Test used ☐ Test used ☐ Test used ☐ FISH ☐ Mixed (partial) ☐ Test used ☐ Test						
Autologous reconstitution (recipient ≥95 %)	□ No □ Yes	☐ Not evaluated				
Autologous reconstitution (recipient ≥95 %)	Overell abima enions	Tull (daman 05.00)		□ Missa d (v		
Not evaluated			n (vaniminut, O		аптат)	
Noticate the Date(s) and results of all tests done for all Donors. Split the results by donor and by the cell type on which the test was performed in infusion of donor or Cord Blood Unit given by the centre Number in order (if applicable)			n (recipient <u>></u> 9:	o %) La Apiasia		
SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE. COPY THIS TABLE AS MANY TIMES AS NECESSARY. Identification of donor or Cord Blood Unit given by the centre Mapplicable Mumber in donor or Cord Blood Unit given by the centre Mapplicable Mapplicable Mapplicable Mapplicable Test used Test used Test used Test used Mapplicable Test used Test used Mapplicable Test used Test used Mapplicable Test used Test used Test used Mapplicable Test used Test used Test used Test used Mapplicable Test used Test used Mapplicable Test used Test u	.	voi evaluateu				
SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE. COPY THIS TABLE AS MANY TIMES AS NECESSARY. Identification of donor or Cord Blood Unit given by the centre Mapplicable Mumber in donor or Cord Blood Unit given by the centre Mapplicable Mapplicable Mapplicable Mapplicable Test used Test used Test used Test used Mapplicable Test used Test used Mapplicable Test used Test used Mapplicable Test used Test used Test used Mapplicable Test used Test used Test used Test used Mapplicable Test used Test used Mapplicable Test used Test u	INDICATE THE DATE(S) AND RE	ESULTS OF ALL TESTS DON	E FOR ALL DONG	ORS.		
Identification of donor or Cord Blood Unit given by the centre Number in the infusion order (# applicable) PB mononuclear cells (PBMC) PB mononuclear cells (PBMC) PM (PB mononuclear cells (PBMC) PB mononuclear cells (PBMC) PM (PB mononuclear cells (PBMC) PB mononuclear cells (P	* *				APPLICABL	E.
Date of test	COPY THIS TABLE AS MANY TIM	MES AS NECESSARY.	1			1
Date of test				Call tyme an	0/	
Date of test						
PB mononuclear cells (PBMC)	Date of test					Test used
Molecular Cytogenetic Seculis Molecular Cytogenetic Cytogene						
N/A				PB mononuclear cells		
N/A				☐ T-cell		
Monocytes % unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown unknown	yyyy niin dd		□ N/A	☐ B-cells	%	
PMNs (neutrophils) % unknown Lymphocytes, NOS				☐ Red blood cells	%	☐ Other:
Lymphocytes, NOS				•	%	П upknown
Myeloid cells, NOS% Other, specify:						L dikilowii
Other, specify:						
BM FISH Molecular Other: BM William					%	
PB mononuclear cells (PBMC) FISH Molecular Cytogenetic Cytogenetic Cytogenetic ABO group Other: Monocytes					%	
				□вм	%	
yyyy mm dd				☐ PB mononuclear cells		
N/A						
Red blood cells Other: Other: Unknown	yyyy mm aa		□ N/A			
□ Monocytes % □ PMNs (neutrophils)						
PMNs (neutrophils)				☐ Monocytes		
Myeloid cells, NOS% Other, specify:				☐ PMNs (neutrophils)	%	unknown
Other, specify:					%	
BM FISH Molecular Monocytes Molecular Molecular Molecular Multiple Multiple Multiple Multiple Multiple Multiple Multiple Mu				-	%	
yyyy mm dd				□ Other, specify:	0/	
yyyy mm dd				Пвм		
yyyy mm dd						☐ FISH
□ N/A □ B-cells% □ ABO group □ Red blood cells% □ Other:					%	
Red blood cells% Dother:	yyyy mm dd					
☐ Monocytes % ☐ unknown			⊔ N/A			
I I I I I I I I I I I I I I I I I I I						U Otner:
- 1 1111 13 (1100ti 0011110) /v				=		unknown

☐ Lymphocytes, NOS%
☐ Myeloid cells, NOS%

..... %

☐ Other, specify:

CIC: Hospital UPN: Patient Number in EBMT database (if kn	nown):		oate	уууу	 mm	 dd
SECONDARY MALIGNANCY, LY	MPHOPROLIFERA	TIVE OR M YEI	LOPROLIF	RATIVE D	DISORDER	DIAGNOSED
□ Previously reported						
☐ Yes, date of diagnosis:						
Diagnosis:	yyyy mm ☐ MDS ☐ Lyr	<i>dd</i> nphoproliferativ	e disorder		Other	
IF THE PATIENT HAS RECEIVED AN A QUESTION	ALLOGRAFT PRIOR TO	THE DIAGNOSIS O	F ACUTE LEI	UKAEMIA, AI	NSWER THE F	FOLLOWING
Is this secondary ma ☐ No	ilignancy a donor ce	II leukaemia?	□ No 【	□ Yes □	☐ Not applic	cable
ADDITIONA	AL TREATME	NT SINCE	LAST F	-OLLO	W UP	
	INCLUDING	CELL TH	ERAPY	•		
Was any additional treatment ☐ No	given for the disc	ease indication	on for tra	nsplant		
☐ Yes: Start date of the add☐ ☐ Unknown	litional treatment sin	ce last report:	уууу		 dd	
-Cell therapy						
Did the disease treatment include at □ No □ Yes: Is this cell in An allo boos rejection.		c boost?	□No	□ Yes	ng, with no ev	vidence of graft
Is this cell in	nfusion an autologou	us boost?	□ No	□ Yes		

CIC:	Hospital UPN:		HSCT D)ate			
Patient Number in EB	BMT database (if knov	vn):			уууу	mm	dd
CELLULA	R THERAPY						
		<u>fined as any number of</u> therapy has been given					
	as necessary.	urerapy rias been given	Sirice ias	ст о роп, сс	ppy triis sec	uon and	Complete it as
Date of first infusion	n: <i>yyyy</i>	v mm dd					
Disease status befo	ore this cellular the	rapy □ CR	□ Not i	in CR	□ Not eval	uated	□ Unknown
Source of control (check all the	cells: □ Allo □ <i>A</i> at apply)	Auto					
	Type of cells (cl	heck all that apply)					
	☐ Donor lympho	ocyte infusion (DLI)					
	☐ Mesenchyma	al cells					
	☐ Fibroblasts						
	☐ Dendritic cells	3					
	□ NK cells						
	☐ Regulatory T	-cells					
	☐ Gamma/delta	a cells					
	Other						
	☐ Unknown						
	Γ	Number of cells infused	l by type				٦
	-	DLI only	U (0 +)			8	4
		Nucleated o	cells (/kg*) (DLI only)	□ Not ev		x 10°	
			(cells/kg*) (DLI only)	□ Not ev		x 10 ⁶	
			(cells/kg*) (DLI only)	□ Not ev		x 10 ⁶	
		Total number of cells in any non DLI infus					
			(cells/kg*) DLI only)	□ Not ev		x 10 ⁶	
	Chronological nu	ımber of this cell therap	oy for this	patient			
	□ Prophy □ Treatn □ Loss/d	ed/protocol		Mixed chin Treatment	for disease naerism viral infection PTLD, EBV	on	oma
Nu	ımber of infusions	within 10 weeks		d given for ti	he same indi	cation)	
		sus Host Disease (after	_	_			n / HSCT):
	Maximum grade	☐ grade 0 (absent)	☐ grade	e 1	☐ grade 2	2	
		grade 3	☐ grade	e 4	☐ present	t, grade	unknown

CIC:Patient Numb	Hosp per in EBMT o	oital UPN: database (if					ate	уууу	 mm	 dd	
☐ No a		erapy exce (planned b	ept transfu efore HSC	sions <i>Pro</i> T took pla	oceed to "Firs	st evidenc			or other type of		<i>)</i> y)
FIRST I	MMUNC	SUPP	RESSI	IVE TF	REATM	ENT E	PISC	DE FO	R THIS	FOLLO)W UI
Reas o	AL NUMBER ON FOR THIS UNITED THE OF PREVIOUS CONTRACT CON	S TREATM ous treatm	ENT	Relapse	VE TREATN				 PR to previo∪ Unknown	us treatme	ent
NUMBER O	F TRANSFUS	SIONS FRO	M LAST F	REPORT							
	RBC		□ <20 u	nits	□ 20-50 —			0 units	☐ None	☐ unk	nown
	RI	BC irradia	ted		☐ No	□ Ye	es	unknov	wn		
	Platelet Pl	s atelets irra	่ □ <20 เ adiated	ınits	☐ 20-50 ☐ No	units		0 units unknow	□ None wn	☐ unk	inown
HAEMATOL Haemoglo Platelets Neutrophi Reticulocy Ferritin	ls		Oata must h	g/dL 10 ⁹ / L	collected wit ☐ Not eva ☐ Not eva	luated	☐ Un	to the treat transfused transfused	I ☐ Trans		
	g/agent <i>Che</i> G Origin	eck at least Brand	one Dose (mg/kg)	Start d	ate		End o	date		
□ Сус					уууу	 mm	dd	Уууу	 mm	dd	
☐ Cyc	lophosphan	nide									
□ Мус	cophenolate	mofetil									
□ G-C	SF										
☐ Ery	thropoietin										
☐ Cor	ticosteroid										
☐ And	drogens										
Ritu	ıximab <i>(Mab</i>	thera)									
☐ Alei	mtuzumab (Campath)									
☐ Oth	er, specify .										

CIC: Hospital UPN: Patient Number in EBMT database (if k				уууу	 mm	 dd	
RESPONSE TO THIS IMMUNOSUPPI	RESSIVE TREATM	MENT EPI	SODE				
☐ Complete remission ☐ No response ☐ Other, specify	☐ Progressio	•	ansfusion and gro	owth factor indeperal	endent)		
Date response evaluated	 <i>yyyy</i>	 mm	 dd				
HAS THE PATIENT UNDERGONI No additional therapy except Yes Photocopy or reprint the File as required.	transfusions						any times
FIRST EVIDENCE	E OF DISE	ASE W	ORSENIA	NG SINCE	LAST H	SCT	
RELAPSE OR PROGRESSION Previously reported No Yes; date diagnosed:							
	уууу	mm	dd				

 $\hfill\square$ Continuous progression

LAST DISEASE AND PATIENT STATUS				
LAST DISEASE STATUS ☐ Stable disease / No response ☐ Complete Remission ☐ Partial Remission ☐ Relapse/Progression				
PNH TESTS (To be filled in only for Aplastic anaemia or PNH at diagnosis) Date of PNH test yyyyy mm dd Size of the PNH clone in %:				
☐ Other, specify	RBC Both In Not done No Yes			
PREGNANCY AFTER HSCT Has patient or partner become pregnant after this HSCT? No Yes: Did the pregnancy result in a live birth? No Yes Unknown Unknown				
SURVIVAL STATUS Alive Dead PERFORMANCE SCORE (if alive) Type of score used Lansky Score	te ☐ 100 (Normal, NED) ☐ Not evaluated ☐ 90 (Normal activity) ☐ Unknown ☐ 80 (Normal with effort) ☐ 70 (Cares for self) ☐ 60 (Requires occasional assistance) ☐ 50 (Requires assistance) ☐ 40 (Disabled) ☐ 30 (Severely disabled) ☐ 20 (Very sick) ☐ 10 (Moribund)			

CIC:

Hospital UPN: Patient Number in EBMT database (if known):

HSCT Date..... - - - - dd

CIC: Hospita	al UPN:	HSCT Date		
Patient Number in EBMT da	tabase (if known):	уууу	mm	dd
MAIN CAUSE OF DEATH	(check only one main cause)			
☐ Relapse or pro	ogression / persistent disease			
	alignancy (including lymphoproliferative o	lisease)		
☐ HSCT related		100000)		
☐ Cell therapy (r	non HSCT) Related Cause (if applicable	le)		
• • •	, , , , , , , , , , , , , , , , , , , ,			
☐ Unknown				
Contrib	outory Cause of Death (check as mar	ny as appropriate):	V N	
	GvHD (if previous allograft)		Yes No	
	Interstitial pneumonitis			
	Pulmonary toxicity			
	Infection			
	bacterial			
	viral			
	fungal		5 5	
	parasitic		5 5	
	Rejection / poor graft function		<u> </u>	
	History of severe Veno-Occlusive di	sorder (VOD)		
	Haemorrhage	,		
	Cardiac toxicity			
	Central nervous system toxicity] 🗆
	Gastro intestinal toxicity			
	Skin toxicity			
	Renal failure			
	Multiple organ failure			
	Other:			
	ADDITIONAL NOTES I	F APPLICABLE		
COMMENTS				
	IDENTIFICATION &	SIGNATURE		