DAY 0

MED-B
GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) ....

Hospital .... Unit ....

Contact person: ....

e-mail ....

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

STUDY/TRIAL

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

Name of study / trial ....

PATIENT

Unique Identification Code (UIC) .... *(to be entered only if patient previously reported)*

Hospital Unique 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) – surname(s))

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

Sex: *(at birth)* ☐ Male ☐ Female

ABO Group ....

Rh factor: ☐ Absent ☐ Present ☐ Not evaluated

DISEASE

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

PRIMARY DISEASE DIAGNOSIS *(CHECK THE DISEASE FOR WHICH THIS TRANSPLANT WAS PERFORMED)*

☐ Primary Acute Leukaemia
- ☐ Acute Myelogenous Leukaemia (AML) & related Precursor Neoplasms
- ☐ Precursor Lymphoid Neoplasms (old ALL)

☐ Therapy related myeloid neoplasms (old Secondary Acute Leukaemia)

☐ Chronic Leukaemia
- ☐ Chronic Myeloid Leukaemia (CML)
- ☐ Chronic Lymphocytic Leukaemia (CLL)

☐ Lymphoma
- ☐ Non Hodgkin
- ☐ Hodgkin's Disease

☐ Myeloma /Plasma cell disorder

☐ Solid Tumour

☐ Myelodysplastic syndromes / Myeloproliferative neoplasm
- ☐ MDS
- ☐ MDS/MPN
- ☐ Myeloproliferative neoplasm

☐ Bone marrow failure including Aplastic anaemia

☐ Inherited disorders
- ☐ Primary immune deficiencies
- ☐ Metabolic disorders

☐ Histiocytic disorders

☐ Autoimmune disease
- ☐ Juvenile Idiopathic Arthritis (JIA)
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus
- ☐ Systemic Sclerosis

☐ Haemoglobinopathy

☐ Other diagnosis, specify:____________________________________

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

DAY 0	MED-B INHERITED DISORDERS

INITIAL DIAGNOSIS

Has the information requested in this section been submitted with a previous HSCT registration?

☐ Yes: go to "Status of Disease at HSCT" on page 4 ☐ No: proceed with this section

CLASSIFICATION

☐ **Primary immune deficiencies**

SCID *(**S**evere **C**ombined **I**mmune **D**eficiency)*

T- B- CELLS SCID

- ☐ Artemis
- ☐ Ligase IV
- ☐ Rag-1 or Rag-2
- ☐ T- B- cells SCID, other
- ☐ T- B- cells SCID, unspecified

T- B+ CELLS SCID

- ☐ γc
- ☐ JAK 3
- ☐ IL-7R alpha
- ☐ ZAP 70 deficiency
- ☐ T- B+ cells SCID, other (CD45, CD3 δ, ε)
- ☐ T- B+ cells SCID, unspecified

☐ ADA deficiency (Adenosine deaminase defic.)

☐ PNP (Purine nucleoside phosphorylase defic.)

☐ Reticular dysgenesis

☐ SCID other, specify: ....

CID *(**C**ombined **I**mmune **D**eficiency)*

- ☐ Omenn syndrome

☐ CID other, specify: ....

Other primary immune deficiencies

- ☐ Agranulocytosis (Kostmann)
- ☐ Ataxia telangiectasia
- ☐ Bare lymphocyte syndrome (lack of HLA ag expression)
- ☐ Cartilage hair hypoplasia / dyskeratosis congenita
- ☐ CD40 Ligand
- ☐ Chediak-Higashi syndrome
- ☐ Chronic granulomatous disease
- ☐ DiGeorge syndrome
- ☐ Griscelli syndrome
- ☐ Interferon γ
- ☐ IPEX syndrome
- ☐ Leukocyte adhesion
- ☐ Wiskott Aldrich syndrome
- ☐ X-linked lymphoproliferative syndrome (Purtilo)

☐ Inherited disorders of metabolism

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

☐ Other inherited disorders

☐ Glanzmann

☐ Platelet defect, not otherwise specified

☐ Osteopetrosis

☐ Osteoclast defect, not otherwise specified

☐ Other, specify ....

☐ Familial lymphohystiocytosis

Stored material ☐ No

☐ Yes:

DNA	☐ No	☐ Yes
PBL	☐ No	☐ Yes
B-cell line	☐ No	☐ Yes
Fibroblasts	☐ No	☐ Yes

Other, specify …………………………………………………………………………

☐ Unknown

INHERITANCE

Tick only one

☐ Autosomal recessive proven ☐ Autosomal recessive suspected
☐ X-linked proven ☐ X-linked suspected
☐ unknown

CYTOGENETICS

Chromosome analysis

☐ Normal ☐ Abnormal ☐ Not done or failed ☐ Unknown

Complete only for SCID patients.

If abnormal:
Mutations

☐ γc ☐ JAK 3 ☐ Rag-1 ☐ Rag-2 ☐ ADA
☐ other: ....

Description NUCLEOTIDES *(in clear text)*

Allele 1* ....

Allele 2 ....

PROTEIN *(in clear text)*

Allele 1* ....

Allele 2 ....

**For* γc, *use Allele 1 only*

STATUS OF DISEASE AT HSCT

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

HAEMATOLOGICAL VALUES

Platelets (10^9/L) ....
(non transfused values)
White Blood Cells (10^9/L) ....
Lymphocytes (10^9/L) ....
T cells (CD3+) (10^9/L) ....
CD4+ cells (10^9/L) ....
CD8+ cells (10^9/L) ....
NK cells (CD56+) (10^9/L) ....
B cells (10^9/L) ....
Granulocytes (10^9/L) ....
Reticulocytes (10^9/L) ....

T-CELL FUNCTION

Mixed leukocyte culture (MLC) reactivity

☐ Absent ☐ Partial ☐ Normal ☐ Not evaluated

Mitogen induced lymphocyte proliferation

☐ Absent ☐ Partial ☐ Normal ☐ Not evaluated

Natural killer activity

☐ Absent ☐ Partial ☐ Normal ☐ Not evaluated

IMMUNOGLOBULINS (B-CELL FUNCTION)

Serum IgM (g/L) .... ☐ Not evaluated

Serum IgA (g/L) .... ☐ Not evaluated

Serum IgG (g/L) .... ☐ Not evaluated

Serum IgE (g/L) .... ☐ Not evaluated

Isohemaglutinin ☐ Absent ☐ Decreased ☐ Normal or elevated ☐ Not evaluated

Antibody response

☐ Absent ☐ Decreased ☐ Normal or elevated ☐ Not evaluated

CLINICAL STATUS

GENERAL MANIFESTATIONS

Renal impairment	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Malnutrition	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Protracted diarrhea	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Respiratory impairment	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown
Liver impairment	☐ No	☐ Yes	☐ Not evaluated	☐ Unknown

INFECTIONS ☐ No ☐ Yes ☐ Unknown

If yes:

SITE	PATHOGEN
Septicemia	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Pulmonary	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Meningeal	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Skin infection	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Liver	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Bone or joints	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Gut infection	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown
Undetermined	☐ Mycobacteria ☐ Bacteria, other ☐ Pneumocystis carinii ☐ Cryptosporidia ☐ Fungi, other ☐ Virus ☐ Other .... ☐ Unknown

SITE	**PATHOGEN**		
Other:	☐ Mycobacteria	☐ Bacteria, other	
	☐ Pneumocystis carinii	☐ Cryptosporidia	☐ Fungi, other
	☐ Virus ☐ Other		☐ Unknown

GVHD STATUS PRIOR TO HSCT

☐ Absent ☐ Present ☐ Not evaluated ☐ Unknown

If present:
Manifestation

Organ affected ☐ Gut ☐ Liver ☐ Skin

Lymphadenopathy ☐ No ☐ Yes ☐ Unknown

Cause of the GvHD ☐ Blood transfusion
☐ Maternal engraftment: Number of maternal T cells . ... 10^9/L
Test used ☐ HLA typing
☐ Microsatellite
☐ IL2 T cell line
☐ Cytogenetics
☐ Unknown

Treatment
☐ No ☐ Yes ☐ Unknown

NUMBER OF TRANSFUSIONS BEFORE HSCT

	NONE	< 20 UNITS	20-50 UNITS	> 50 UNITS	UNKNOWN
RBC	☐	☐	☐	☐	☐
Platelets	☐	☐	☐	☐	☐

Non irradiated products infused ☐ No ☐ Yes ☐ Unknown

FORMS TO BE FILLED IN

TYPE OF HSCT

☐ AUTOgraft, **proceed to Autograft day 0 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 0 form**

If ☐ Other : ...., contact the EBMT Central Registry Office for instructions

DAY 100	MED-B INHERITED DISORDERS

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

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

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

Name of study / trial ....

Hospital Unique Patient Number ....

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

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

Sex: ☐ Male ☐ Female
(at birth)

Date of last HSCT for this patient: .... - .... - ....
yyyy mm dd

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

DISEASE STATUS AT 100 DAYS AFTER HSCT

☐ Cured ☐ Improved ☐ No change ☐ Worse ☐ Unknown

Date of assessment .... - .... - .... *(As close to the 100 day interval as possible)*
yyyy mm dd

RECONSTITUTION

CHIMAERISM

T-cell ☐ Full: Date achieved .... - .... - ....
yyyy mm dd
☐ Mixed ☐ Absent ☐ Not evaluated

B-cell	☐ Full	☐ Partial	☐ Absent	☐ Not evaluated
Granulocyte	☐ Full	☐ Partial	☐ Absent	☐ Not evaluated
Monocyte	☐ Full	☐ Partial	☐ Absent	☐ Not evaluated
Red cell	☐ Full	☐ Partial	☐ Absent	☐ Not evaluated
Platelets	☐ Full	☐ Partial	☐ Absent	☐ Not evaluated

HAEMATOLOGICAL RECONSTITUTION

Haemoglobin (g/dL) ....

Platelets (10^9/L) ....

T-cells (CD3+) (10^9/L) ....

B-cells (10^9/L) ....

Granulocytes (10^9/L) ....

IMMUNOLOGICAL RECONSTITUTION

T-cells

Mixed leukocyte culture (MLC) reactivity

☐ Absent ☐ Partial ☐ Normal ☐ Not evaluated

Mitogen induced lymphocyte proliferation

☐ Absent ☐ Partial ☐ Normal ☐ Not evaluated

B-cells

Serum IgM (g/L) .... ☐ Not evaluated

Serum IgA (g/L) .... ☐ Not evaluated

Serum IgG (g/L) .... ☐ Not evaluated

Serum IgE (g/L) .... ☐ Not evaluated

Antibody production after vaccination

☐ Absent ☐ Decreased ☐ Normal or elevated ☐ Not evaluated

ON-GOING TREATMENT FOR RECONSTITUTION AT 100 DAYS

☐ No

☐ Yes: Patient still receiving IV Immunoglobulins ☐ No ☐ Yes ☐ Unknown

Growth factors (cytokines) administered to the patient? ☐ No ☐ Yes ☐ Unknown

☐ Unknown

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

☐ AUTOgraft, **proceed to Autograft day 100 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 100 form**

FOLLOW UP	MED-B INHERITED DISORDERS

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

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

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

Name of study / trial ....

Hospital Unique Patient Number ....

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

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

Sex: ☐ Male ☐ Female
(at birth)

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

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH: ....…..... - .... - ....
yyyy mm dd

Complications after Transplant (Allografts)

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

Maximum grade ☐ grade 0 *(Absent)* ☐ grade I ☐ grade II ☐ grade III ☐ grade IV ☐ Not evaluated

If present: ☐ New onset ☐ Recurrent ☐ Persistent

Reason: ☐ Tapering ☐ DLI ☐ Unexplained

Date onset of this episode: ....- .... - .... ☐ Not applicable
(if new or recurrent) *yyyy mm dd*

Stage:

Skin	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV	
Liver	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV	
Lower GI tract	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV	
Upper GI tract	☐ 0 (none)	☐ I				

Other site affected ☐ No ☐ Yes

Resolution

☐ No ☐ Yes: Date of resolution: ....- .... - ....
yyyy mm dd

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

CHRONIC GRAFT VERSUS HOST DISEASE (cGvHD)

Presence of cGvHD

☐ No
☐ Yes: ☐ First episode
☐ Recurrence

Date of onset .... - .... - ....
yyyy mm dd

☐ Present continuously since last reported episode

Maximum extent during this period
☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score during this period
☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

Organs affected ☐ Skin ☐ Gut ☐ Liver ☐ Mouth
☐ Eyes ☐ Lung ☐ Other, specify .... ☐ Unknown

☐ Resolved: Date of resolution: .... - .... - ....
yyyy mm dd

OTHER COMPLICATIONS SINCE LAST REPORT

PLEASE USE THE DOCUMENT "DEFINITIONS OF INFECTIOUS DISEASES AND COMPLICATIONS AFTER STEM CELL TRANSPLANTATION" TO FILL THESE ITEMS.

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Bacteremia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		
ARDS		
Multiorgan failure due to infection		
ENDORGAN DISEASES		
Pneumonia		

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		
Retinitis		
Other:		
		yyyy mm dd

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

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

NON INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type *(Check all that are applicable for this period)*	**Yes**	**No**	**Unknown**	**Date**
Idiopathic pneumonia syndrome	☐	☐	☐	
VOD	☐	☐	☐	
Cataract	☐	☐	☐	
Haemorrhagic cystitis, non infectious	☐	☐	☐	
ARDS, non infectious	☐	☐	☐	
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

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

(ALLOS ONLY)

Graft loss / **Overall chimaerism:**

- ☐ No:
  - ☐ Full *(donor >95 %)*
  - ☐ Mixed *(partial)*
- ☐ Yes:
  - ☐ Autologous reconstitution *(recipient >95 %)*
  - ☐ Aplasia
- ☐ Not evaluated

INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS.

SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE.

COPY THIS TABLE AS MANY TIMES AS NECESSARY.

Date of test	Identification of donor or Cord Blood Unit given by the centre	Number in the infusion order *(if applicable)*	Cell type on which test was performed / % Donor cells	Test used
.... - .... - .... *yyyy mm dd*	....	.... ☐ N/A	☐ BM …….. % ☐ PB mononuclear cells (PBMC) ….. …% ☐ T-cell …….. % ☐ B-cells …….. % ☐ Red blood cells ….. …% ☐ Monocytes …….. % ☐ PMNs (neutrophils) …….. % ☐ Lymphocytes, NOS ….. …% ☐ Myeloid cells, NOS …….. % ☐ Other, specify: …………………… …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …………………… ☐ unknown
.... - .... - .... *yyyy mm dd*	....	.... ☐ N/A	☐ BM …….. % ☐ PB mononuclear cells (PBMC) ….. …% ☐ T-cell …….. % ☐ B-cells …….. % ☐ Red blood cells ….. …% ☐ Monocytes …….. % ☐ PMNs (neutrophils) …….. % ☐ Lymphocytes, NOS ….. …% ☐ Myeloid cells, NOS …….. % ☐ Other, specify: …………………… …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …………………… ☐ unknown
.... - .... - .... *yyyy mm dd*	....	.... ☐ N/A	☐ BM …….. % ☐ PB mononuclear cells (PBMC) ….. …% ☐ T-cell …….. % ☐ B-cells …….. % ☐ Red blood cells ….. …% ☐ Monocytes …….. % ☐ PMNs (neutrophils) …….. % ☐ Lymphocytes, NOS ….. …% ☐ Myeloid cells, NOS …….. % ☐ Other, specify: …………………… …….. %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: …………………… ☐ unknown

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

☐ Previously reported

☐ Yes, date of diagnosis: .... - .... - ....
yyyy mm dd

Diagnosis: ☐ AML ☐ MDS ☐ Lymphoproliferative disorder ☐ Other ....

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

Is this secondary malignancy a donor cell leukaemia**?** ☐ No ☐ Yes ☐ Not applicable

☐ No

ADDITIONAL DISEASE TREATMENT SINCE LAST FOLLOW UP
(INCLUDES CELL THERAPY)

Was any additional treatment given for the disease indication for transplant

☐ No

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

☐ Unknown

-Cell therapy

Did the disease treatment include additional cell infusions *(**excluding a new HSCT**)*

☐ No

☐ Yes: Is this cell infusion an allogeneic boost? ☐ No ☐ Yes
An allo boost is an infusion of cells from the same donor without conditioning, with no evidence of graft rejection.

Is this cell infusion an autologous boost? ☐ No ☐ Yes

⇨ **If cell infusion is <u>not</u> a boost, please complete CELLULAR THERAPY on the following page**

If yes:

CELLULAR THERAPY

One cell therapy regimen is defined as any number of infusions given within 10 weeks for the same indication. If more than one regimen of cell therapy has been given since last report, copy this section and complete it as many times as necessary.

- ☐ No
- ☐ Yes: Disease status before this cellular therapy ☐ CR ☐ Not in CR ☐ Not evaluated
- ☐ Unknown

If yes:

Type of cells

- ☐ Donor lymphocyte infusion (DLI)
- ☐ Mesenchymal cells
- ☐ Fibroblasts
- ☐ Dendritic cells
- ☐ NK cells
- ☐ Regulatory T-cells
- ☐ Gamma/delta cells
- ☐ Other ....
- ☐ Unknown

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

Chronological number of this cell therapy for this patient .....

Indication *(check all that apply)*

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

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

Acute Graft Versus Host Disease *(after this infusion but before any further infusion / transplant)*:

Maximum grade ☐ grade 0 (absent) ☐ grade 1 ☐ grade 2
☐ grade 3 ☐ grade 4 ☐ present, grade unknown

-Chemo / radiotherapy

ADDITIONAL DISEASE TREATMENT GIVEN EXCLUDING CELL INFUSION?

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

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Cured ☐ Improved ☐ Unchanged ☐ Worse

PREGNANCY AFTER TRANSPLANT

Has patient or partner become pregnant after this HSCT?

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

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

SURVIVAL STATUS

☐ Alive
☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

SCORE
☐ 100 (Normal, NED)
☐ 90 (Normal activity)
☐ 80 (Normal with effort)
☐ 70 (Cares for self)
☐ 60 (Requires occasional assistance)
☐ 50 (Requires assistance)
☐ 40 (Disabled)
☐ 30 (Severely disabled)
☐ 20 (Very sick)
☐ 10 (Moribund)

☐ Not evaluated
☐ Unknown

MAIN CAUSE OF DEATH *(if dead)*

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

☐ Unknown
☐ Other : ....

....

ADDITIONAL NOTES IF APPLICABLE

COMMENTS ....

....

IDENTIFICATION & SIGNATURE

....