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

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

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

PATIENT

ANTIBODIES IN THE PATIENT *(before transplantation)*

ANTIGENS *(if testing applicable)*

VHIVPAT	HIV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
VCMVPAT	CMV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	HIVPATM			
VEBVPAT	EBV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	HBVSPATM			
HBVSPAT	HBVs	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
HBVCPAT	HBVc	☐Negative	☐Positive	☐Not evaluated	☐Unknown	HBVEPATM			
HBVEPAT	HBVe	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
VHCVPAT	HCV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐ Negative	☐Positive	☐Not evaluated	☐Unknown
VHTLVPAT	HTLV.I	☐Negative	☐Positive	☐Not evaluated	☐Unknown	VHCVPATM			
VTOXPAT	Toxoplasmosis	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
VOTABPAT	Other	☐Negative	☐Positive	Specify…… VPATANTI					

PRE-TRANSPLANT HISTORY OF DOCUMENTED INVASIVE FUNGAL INFECTION SINCE INITIAL DIAGNOSIS

☐ No VHPETBVC

☐ Yes:

Candida	☐ Yes	☐ No	☐ Unknown	VPTCANDI
Aspergillus	☐ Yes	☐ No	☐ Unknown	VPTASPER
Pneumocystis carinii	☐ Yes	☐ No	☐ Unknown	VPTPNECA
Other VPTOTHFU	☐ Yes	☐ No	If Yes, specify	VOTHFUNG

☐ Unknown

PERFORMANCE SCORE

Type of score used ☐ Karnofsky ☐ LanskyPERFSYST

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

☐ 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): ..... WEIGHTB

HEIGHT **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 **COMORBID**

Comorbidity	Definitions	No	Yes	Not evaluated
Solid tumour, previously present **MALIGN**	Treated at any time point in the patient's past history, excluding non-melanoma skin cancer Indicate type ..... **DISMCLFD**	☐	☐	☐
Inflammatory bowel disease **INBWDIS**	Crohn's disease or ulcerative colitis	☐	☐	☐
Rheumatologic **RHEUMAT**	SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica	☐	☐	☐
Infection **INFECPRE**	Requiring continuation of antimicrobial treatment after day 0	☐	☐	☐
Diabetes **TRTDEPDB**	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 **HEPATIC**	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 **ARRYTHBL**	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 **STROKE**	Transient ischemic attack or cerebrovascular accident	☐	☐	☐
Heart valve disease **VALVE**	Except mitral valve prolapse	☐	☐	☐
Pulmonary: moderate **PULMONC**	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 **OBESITY**	Patients with a body mass index > 35 kg/m2	☐	☐	☐
Peptic ulcer **PEPTICU**	Requiring treatment	☐	☐	☐
Psychiatric disturbance **PSYCH**	Depression or anxiety requiring psychiatric consultation or treatment	☐	☐	☐

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

..... **OTHCLIAB**

DONOR AND STEM CELL SOURCE

Multiple donors
(including multiple CB units)

☐ No **VMULTDON** **NUMDONRS**
☐ Yes: Number of donors .....

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

DONOR 1

IDAABCCH

HLA MATCH TYPE *(DONOR RELATION WITH PATIENT)* DONRL

- ☐ 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
  ALLMISRL ☐ >=2 HLA loci mismatch

Donor ID given by the centre .....
DONORID2

HLA MISMATCHES BETWEEN DONOR AND PATIENT

*(**Mismatched relatives only**. If you are submitting the HLA typing results, you can skip this item)*

Complete number of mismatches inside each box

A	B	C	DRB1	DQB1	DPB1 MMSERA MMSERB MMSERC MMSERDR MMSERDQ MMSERDP	
☐	☐	☐	☐	☐	☐	Antigenic
☐	☐	☐	☐	☐	☐	Allelic

0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated MMALLA MMALLB MMALLC MMALLDR MMALLDQ MMALLDP

- ☐ Unrelated donor

BMDW code of the Donor Registry or Cord Blood Bank (*up to 4 characters*) .... WMDAID

ION of the Donor Registry or Cord Blood Bank (*up to 4 numbers*) .... IONDR

Name of donor registry or Cord Blood Bank .... DONREGID

Donor centre name or code *(if applicable)* ..... *(optional)* GERDONCEN

Donor ID given by the Donor Registry or the Cord Blood Bank listed above ..... DONORID

Patient ID given by the Donor Registry or the Cord Blood Bank listed above ..... PATIEID

DONOR INFORMATION

Blood group: ☐ A ☐ B ☐ AB ☐ O ABODON

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

OR Age at time of donation ..... *years* ..... *month*
(if date of birth not provided)

Sex: ☐ Male ☐ Female DONSEX *(at birth)*

STATUS OF THE DONOR OR CORD BLOOD UNIT BEFORE HSCT

	SEROLOGY				ANTIGENS *(if applicable)*
VHIVDON	HIV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VCMVDON	CMV	☐ Negative	☐ Positive	☐ Not evaluated	HIVDONM
VEBVDON	EBV	☐ Negative	☐ Positive	☐ Not evaluated	HBVSDO NM
HBVSDON	HBVs	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HBVCDON	HBVc	☐ Negative	☐ Positive	☐ Not evaluated	HBVEDONM
HBVEDON	HBVe	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VHCVDON	HCV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VHTLVDON	HTLV.I	☐ Negative	☐ Positive	☐ Not evaluated	VHCVDONM
SY PHLDON	Syphilis	☐ Negative	☐ Positive	☐ Not evaluated	
VTOXDON	Toxoplasmosis	☐ Negative	☐ Positive	☐ Not evaluated	
VOTABDON	Other	☐ Negative	☐ Positive	Specify..... VDONANTI	

Did this donor provide more than one stem cell product FOR THIS TRANSPLANT? (e.g. Bone Marrow, Peripheral Blood, Cord Blood product) DIFFSCPRD

- ☐ No
- ☐ Yes: Number of different stem cell products infused from this donor ..... NUMS

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

DONOR 1 – PRODUCT NUMBER 1

SOURCE OF STEM CELLS FOR THIS PRODUCT**, SELECT ONLY ONE** STEMCEDO1

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: STEMCEOT1

Date of collection, including cord blood: .... - .... - ....
DATEHARV1 yyyy mm dd

Growth factors administered to the donor VCYTOKDN

☐ No VCYTOSD ☐ Yes, specify: ..... ☐ Not applicable (Cord Blood)

MANIPULATION FOR THIS PRODUCT

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

☐ No ☐ Yes:

Negative ☐ No ☐ Yes: EXVIMAND1

TCDEPMAB1 ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*

TCABDEPL1 ☐ T-cell receptor αβ depletion

BCDEPMAB1 ☐ B-cell depletion (CD19+) by MoAB

NKCDEPMA1 ☐ NK cell depletion by MoAB

ELUTRIAT1 ☐ Elutriation

NEGSELDO1 ☐ Other: .....

Positive ☐ No ☐ Yes:

MOABPSD1 ☐ Monoclonal antibodies: CD34+ enrichment

MOABPSDO1 Other

☐ Other: .....
POSSELDO POSSELDS1

Expansion ☐ No ☐ Yes EXPANSID1

Genetic manipulation ☐ No ☐ Yes GENEMAND1

CELL COUNTS FOR THIS PRODUCT

Total number of Cells Infused (per kg of recipient body weight)

Type	Counts	x 10^5	x 10^6	x 10^7	X10^8	
Nucleated cells (/kg)INFNUC1	.... -	☐	☐	☐	☐	NUCUNIT1
CD 34+ (cells/kg) INF34PC1	.... -	☐	☐	☐	☐	CD34UNIT1
T-cells (CD 3+) (cells/kg) INF3PC1	.... -	☐	☐	☐	☐	CD3UNIT1

⇨ **(All products) Please enter the LABORATORY RESULTS WITH HLA TYPING into the database**

CORD BLOOD ONLY

CELL INFUSION METHOD FOR THIS PRODUCT

Route of infusion INFUSRT

☐ Intravenous (IV) ☐ intrabone / intramedullary

☐ Other, specify: ..... ☐ unknown INFUSRTO

Infusion methodINFUSMET

☐ DMSO ☐Wash (Rubinstein/New York) INFUSME0

☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on: CBQCVBTC

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used CBQCVBMC

☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide

☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... % CBQCVBND

Viability of CD34+ cells ..... %CBQCVC34

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

DONOR 1 – PRODUCT NUMBER 2

SOURCE OF STEM CELLS FOR THIS PRODUCT**, SELECT ONLY ONE** STEMCEDO2

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: STEMCEOT2

Date of collection, including cord blood: .... - .... - ....
DATEHARV2 yyyy mm dd

Growth factors administered to the donor VCYTOKDN

☐ No VCYTOSD ☐ Yes, specify: ..... ☐ Not applicable (Cord Blood)

MANIPULATION FOR THIS PRODUCT

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

☐ No ☐ Yes:

Negative ☐ No ☐ Yes: EXVIMAND1

TCDEPMAB1 ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*

TCABDEPL1 ☐ T-cell receptor αβ depletion

BCDEPMAB1 ☐ B-cell depletion (CD19+) by MoAB

NKCDEPMA1 ☐ NK cell depletion by MoAB

ELUTRIAT1 ☐ Elutriation

NEGSELDO1 ☐ Other: .....

Positive ☐ No ☐ Yes:

MOABPSD1 ☐ Monoclonal antibodies: CD34+ enrichment

MOABPSDO2 Other

☐ Other: .....
POSSELDO POSSELDS1

Expansion ☐ No ☐ Yes EXPANSID1

Genetic manipulation ☐ No ☐ Yes GENEMAND1

CELL COUNTS FOR THIS PRODUCT

Total number of Cells Infused (per kg of recipient body weight)

Type	Counts	x 10^5	x 10^6	x 10^7	X10^8	
Nucleated cells (/kg)INFNUC2	.... -	☐	☐	☐	☐	NUCUNIT2
CD 34+ (cells/kg) INF34PC2	.... -	☐	☐	☐	☐	CD34UNIT2
T-cells (CD 3+) (cells/kg) INF3PC2	.... -	☐	☐	☐	☐	CD3UNIT2

⇨ **(All products) Please enter the LABORATORY RESULTS WITH HLA TYPING into the database**

CORD BLOOD ONLY

CELL INFUSION METHOD FOR THIS PRODUCT

Route of infusion INFUSRT

☐ Intravenous (IV) ☐ intrabone / intramedullary

☐ Other, specify: ..... ☐ unknown INFUSRTO

Infusion methodINFUSMET

☐ DMSO ☐Wash (Rubinstein/New York) INFUSME0

☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on: CBQCVBTC

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used CBQCVBMC

☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide

☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... % CBQCVBND

Viability of CD34+ cells ..... %CBQCVC34

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

DONOR 2

IDAABCCH

HLA MATCH TYPE *(DONOR RELATION WITH PATIENT)* DONRL

- ☐ 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 ALLMISRL ☐ >=2 HLA loci mismatch

Donor ID given by the centre .....
DONORID2

HLA MISMATCHES BETWEEN DONOR AND PATIENT

*(**Mismatched relatives only**. If you are submitting the HLA typing results, you can skip this item)*

Complete number of mismatches inside each box

A	B	C	DRB1	DQB1	DPB1	MMSERA MMSERB MMSERC MMSERDR MMSERDQ MMSERDP
☐	☐	☐	☐	☐	☐	Antigenic
☐	☐	☐	☐	☐	☐	Allelic

0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated MMALLA MMALLB MMALLC MMALLDR MMALLDQ MMALLDP

☐ Unrelated donor

BMDW code of the Donor Registry or Cord Blood Bank (*up to 4 characters)* .... WMDAID

ION code of the Donor Registry or Cord Blood Bank (*up to 4 characters)* .... IONDR

Name of donor registry or Cord Blood Bank .... DONREGID

Donor centre name or code *(if applicable)* ..... *(optional)* GERDONCEN

Donor ID given by the Donor Registry or the Cord Blood Bank listed above ..... DONORID

Patient ID given by the Donor Registry or the Cord Blood Bank listed above ..... PATIEID

DONOR INFORMATION

Blood group: ☐ A ☐ B ☐ AB ☐ O ABODON

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

OR Age at time of donation …… *years* …….. *month*
(if date of birth not provided)

Sex: ☐ Male ☐ Female DONSEX

STATUS OF THE DONOR OR CORD BLOOD UNIT BEFORE HSCT

	SEROLOGY				ANTIGENS *(if applicable)*
VHIVDON	HIV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VCMVDON	CMV	☐ Negative	☐ Positive	☐ Not evaluated	HIVDONM
VEBVDON	EBV	☐ Negative	☐ Positive	☐ Not evaluated	HBVSDO NM
HBVSDON	HBVs	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HBVCDON	HBVc	☐ Negative	☐ Positive	☐ Not evaluated	HBVEDONM
HBVEDON	HBVe	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VHCVDON	HCV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
VHTLVDON	HTLV.I	☐ Negative	☐ Positive	☐ Not evaluated	VHCVDONM
SY PHLDON	Sy Philis	☐ Negative	☐ Positive	☐ Not evaluated	
VTOXDON	Toxoplasmosis	☐ Negative	☐ Positive	☐ Not evaluated	
VOTABDON	Other	☐ Negative	☐ Positive	Specify…… VDONANTI	

Did this donor provide more than one stem cell product FOR THIS TRANSPLANT? (e.g. Bone Marrow, Peripheral Blood, Cord Blood product) DIFFSCPRD

- ☐ No
- ☐ Yes: Number of different stem cell products infused from this donor ..... NUMSCPRD

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

DONOR 2 – PRODUCT NUMBER 1

SOURCE OF STEM CELLS FOR THIS PRODUCT**, SELECT ONLY ONE** STEMCEDO1

☐ Bone Marrow ☐ Peripheral Blood
☐ Cord Blood ☐ Other: STEMCEOT1

Date of collection, including cord blood: .... - .... - ....
DATEHARV1 yyyy mm dd

Growth factors administered to the donor VCYTOKDN

☐ No VCYTOSD ☐ Yes, specify: ..... ☐ Not applicable (Cord Blood)

MANIPULATION FOR THIS PRODUCT
Graft manipulation *ex-vivo* including T-cell depletion *other than for RBC removal or volume reduction*
☐ No ☐ Yes:

Negative: ☐ No ☐ Yes: EXVIMAND1
TCDEPMAB1 ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*
TCABDEPL1 ☐ T-cell receptor αβ depletion
BCDEPMAB1 ☐ B-cell depletion (CD19+) by MoAB
NKCDEPMA1 ☐ NK cell depletion by MoAB

ELUTRIAT1 ☐ Elutriation
NEGSELDO1 ☐ Other: .....

Positive: ☐ No ☐ Yes:
☐ CD34+ enrichment IDAABCCD
☐ Monoclonal antibodies MOABPSD1
☐ Other POSSELDO POSSELDS1

Expansion ☐ No ☐ Yes EXPANSID1

Genetic manipulation ☐ No ☐ Yes GENEMAND1

CELL COUNTS FOR THIS PRODUCT
Total number of Cells Infused (per kg of recipient body weight)

Type	Counts	x 10^5	x 10^6	x 10^7	X10^8	
Nucleated cells (/kg) INFNUC1	.... -	☐	☐	☐	☐	NUCUNIT1
CD 34+ (cells/kg) INF34PC1	.... -	☐	☐	☐	☐	CD34UNIT1
T-cells (CD 3+) (cells/kg) INF3PC1	.... -	☐	☐	☐	☐	CD3UNIT1

⇨ **(All products) Please enter the LABORATORY RESULTS WITH HLA TYPING into the database**

CORD BLOOD ONLY

CELL INFUSION METHOD FOR THIS PRODUCT

Route of infusion INFUSRT
☐ Intravenous (IV) ☐ intrabone / intramedullary
☐ Other, specify: ..... ☐ unknown INFUSRTO

Infusion method INFUSMET
☐ DMSO ☐ Wash (Rubinstein/New York) INFUSME0
☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT
Tests performed after thawing of an aliquot on: CBQCVBTC
☐ Contiguous segment ☐ Reference bag ☐ unknown
Method used CBQCVBMC
☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide
☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... % CBQCVBND

Viability of CD34+ cells ..... % CBQCVC34

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

DONOR 2– PRODUCT NUMBER 2

SOURCE OF STEM CELLS FOR THIS PRODUCT**, SELECT ONLY ONE** STEMCEDO1

☐ Bone Marrow ☐ Peripheral Blood
☐ Cord Blood ☐ Other: STEMCEOT2

Date of collection, including cord blood: .... - .... - ....
DATEHARV2 *yyyy mm dd*

Growth factors administered to the donor VCYTOKDN

☐ No VCYTOSD ☐ Yes, specify: ..... ☐ Not applicable (Cord Blood)

MANIPULATION FOR THIS PRODUCT
Graft manipulation *ex-vivo* including T-cell depletion *other than for RBC removal or volume reduction*

☐ No ☐ Yes:

Negative: ☐ No ☐ Yes: EXVIMAND2

TCDEPMAB2 ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*
TCABDEPL2 ☐ T-cell receptor αβ depletion
BCDEPMAB2 ☐ B-cell depletion (CD19+) by MoAB
NKCDEPMA2 ☐ NK cell depletion by MoAB

ELUTRIAT2 ☐ Elutriation
NEGSELDO2 ☐ Other: .....

Positive: ☐ No ☐ Yes:
☐ CD34+ enrichment IDAABCCD2
☐ Monoclonal antibodies MOABPSD2
☐ Other POSSELD2 POSSELDS2

Expansion ☐ No ☐ Yes EXPANSID2

Genetic manipulation ☐ No ☐ Yes GENEMAND2

CELL COUNTS FOR THIS PRODUCT
Total number of Cells Infused (per kg of recipient body weight)

Type	Counts	x 10^5	x 10^6	x 10^7	X10^8	
Nucleated cells (/kg)INFNUC2	.... -	☐	☐	☐	☐	NUCUNIT2
CD 34+ (cells/kg) INF34PC2	.... -	☐	☐	☐	☐	CD34UNIT2
T-cells (CD 3+) (cells/kg) INF3PC2	.... -	☐	☐	☐	☐	CD3UNIT2

⇨ **(All products) Please enter the LABORATORY RESULTS WITH HLA TYPING into the database**

CORD BLOOD ONLY

CELL INFUSION METHOD FOR THIS PRODUCT

Route of infusion INFUSRT
☐ Intravenous (IV) ☐ intrabone / intramedullary
☐ Other, specify: ..... ☐ unknown INFUSRTO

Infusion methodINFUSMET
☐ DMSO ☐Wash (Rubinstein/New York) INFUSME0
☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT
Tests performed after thawing of an aliquot on: CBQCVBTC
☐ Contiguous segment ☐ Reference bag ☐ unknown
Method used CBQCVBMC
☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide
☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... % CBQCVBND

Viability of CD34+ cells ..... % CBQCVC34

HSC TRANSPLANTATION

Chronological number of HSCT for this patient ..... **BMTNR**

If >1, date of last HSCT before this one: ..... - .....-..... **VPREVDOG**
VPASTGRF *yyyy mm dd*

If >1, type of last HSCT before this one: ☐ Allo ☐ Auto ☐ N/A

If >1 and Allograft, was the same donor used for all prior and current HSCTs? ☐ No ☐ Yes **SAMEDONO**

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

Name of the institution ..... **OTHINSTN**

City ..... **INSTCITY**

⇨ 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.

HSCT part of a multiple graft protocol (program)? **VMULGRAF**

☐ No
☐ Yes: Type of multiple graft protocol ..... **DBLAUTO**
Graft number in the protocol _____ out of _____ total number of HSCTs in the program
☐ Unknown **VGRNBPR** **VSEQPROT**

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

PREPARATIVE TREATMENT *(conditioning)*

PREPARATIVE (CONDITIONING) REGIMEN GIVEN **VCONDITI**

☐ No (*Usually Paediatric Inherited Disorders only*) *CONTINUE TO PAGE 14*
☐ Yes: Was regimen intended **MYELOABR**
to be myeloablative ☐ No:

	Reason not myeloablative	Main reason *(tick only one)*	Additional reason *(tick as many as necessary)*
REASRI	Age of recipient	☐	☐
	Comorbid conditions	☐	☐
	Prior HSCT	☐	☐
	Protocol driven **REASRIOT**	☐	☐
	Other, specify	☐	☐

☐ Yes
☐ Unknown

Drugs ☐ No ☐ Yes ☐ Unknown **VCHEMOTH**
(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 IDAABCCD DOSE DOSEUNIT

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 ANIMORIG ORIGIN Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify....		☐ mg/m²	☐ mg/Kg	
☐ Bleomycin		☐ mg/m²	☐ mg/Kg	
☐ Busulfan ROUTADM ☐ 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	OTHECHEM	☐ mCi	☐ MBq	
☐ Other MoAB, specify ……	OTHECHEM	☐ mg/m²	☐ mg/Kg	
☐ Other, specify ……	OTHECHEM	☐ mg/m²	☐ mg/Kg	

TBI VRADICON ☐ No ☐ Yes ☐ Unknown

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

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

Local radiotherapy VRADIOTH ☐ No ☐ Yes ☐ Unknown

GvHD PREVENTION IN THE RECIPIENT

☐ No VAGVHDP

☐ Yes: ☐ Drugs *(Immunosuppressive chemo)* VAGVHDP5 IDAABCCD

- ☐ ALG, ALS, ATG, ATS *(given after day 0)*: Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify.... .....
- ☐ Anti CD25 *(MoAB in vivo)* ANIMORIG ORIGIN
- ☐ 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 ..... OTHECHEM
- ☐ Other agent *(in vivo)*, specify.....

☐ Extra-corporeal photopheresis (ECP) ECP

☐ Other: VAGVHDP9 AGVHDP10

SURVIVAL STATUS ON DATE OF HSCT VPATSTAT

☐ Alive
☐ Dead
☐ Patient died between administration of the preparative regimen and date of HSCT

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

☐ Relapse or Progression/Persistent disease ☐ HSCT Related Cause
☐ Unknown
☐ Other: ..... DEACSBMU

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

	(check as many as appropriate)	Yes	No	Unknown
VCSDTGVH	GvHD *(if previous allograft)*	☐	☐	☐
VCSDTINP	Interstitial pneumonitis	☐	☐	☐
VCSDTPTX	Pulmonary toxicity	☐	☐	☐
VCSDTINF	Infection	☐	☐	☐
VCSDTBAC	bacterial	☐	☐	☐
VCSDTVIR	viral	☐	☐	☐
VCSDTFUN	fungal	☐	☐	☐
VCSDTPAR	parasitic	☐	☐	☐
VCSDTREJ	Rejection / poor graft function	☐	☐	☐
VCSDTVOD	History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
VCSDTHMR	Haemorrhage	☐	☐	☐
VCSDTCTX	Cardiac toxicity	☐	☐	☐
VCSDTCNS	Central nervous system toxicity	☐	☐	☐
VCSDTGIT	Gastro intestinal toxicity	☐	☐	☐
VCSDTSKI	Skin toxicity	☐	☐	☐
VCSDTREN	Renal failure	☐	☐	☐
VCSDTMOF	Multiple organ failure	☐	☐	☐

Other: ..... DEACSBMR

ADDITIONAL NOTES IF APPLICABLE

FOR ALL DISEASES	MED-B ALLOGRAFT REGISTRATION – DAY 100

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

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

Hospital Unique Patient Number ..... **UPN**

Initials: ....._..... (first name(s)_surname(s)) **GIVNAME FAMNAME**

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

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

RECOVERY and GRAFT PERFORMANCE

Absolute neutrophil count (ANC) recovery *(Neutrophils ≥0.5X10⁹ /L)* **ENGNEUT**
☐ No: Date of last assessment: ..... - ..... - ..... **DNOENGR**
yyyy mm dd
☐ Yes: Date of ANC recovery: ..... - ..... - ..... *(first of 3 consecutive values after 7 days without transfusion containing neutrophils)*
DATCRGR2 *yyyy mm dd*
☐ Never below
☐ Unknown

Platelet recovery
Platelets **≥20** x 10^9/l*; (first of 3 consecutive values after 7 days without platelet transfusion)*
☐ No
☐ Yes: Date Platelets ≥ 20 x 10^9/l ..... - ..... - .....
DPLAT20 *yyyy mm dd* **VPLAT20A**
☐ 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 platelet transfusion)*
☐ No
☐ Yes: Date Platelets ≥ 50 x 10^9/l ..... - ..... - .....
DPLAT50 *yyyy mm dd* **VPLAT50A**
☐ Never below this level
☐ Date unknown: patient discharged before levels reached
☐ Date unknown: out-patient
☐ Unknown

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

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

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

HAEMOPOIETIC CHIMAERISM CHMPB

Overall chimaerism

- ☐ Full *(donor ≥95 %)*
- ☐ Patient reconstitution *(recipient ≥95 %)*
- ☐ Not informative
- ☐ Mixed *(partial)*
- ☐ 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)*	**CELLTEST** **Cell type on which test was performed**	**% Donor cells**	**CHICYD CHIFISD CHIMOD CHIABOD CHIOTHD CHIOTHSD** **Test used**
IDAABCECM .... - ..... - .... *yyyy* *mm* *dd*	DONORID3	INFUSNU3 ..... ☐ N/A CHIDONRC CHIDONMN CHIDONPM CHIDONLY CHIDONMY CHIDONOT CHIDONOS	☐ BM CHIDONBM ☐ PB mononuclear cells (PBMC) CHIDONPB ☐ T-cell CHIDONTC ☐ B-cells CHIDONBC ☐ 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

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

TREATMENT FOR EARLY GRAFT LOSS OR NON-RECOVERY
(If engraftment failure) TRTGRFAI

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

  Date: .... - .... - ....
  yyyy mm dd
  ☐ AUTOgraft *(must have prior conditioning)* DATOTBMT
  ☐ ALLOgraft GFTYPTRA
- ☐ Autologous PBSC re-infusion/boost *(no preparative treatment or conditioning)* GRAFAIPB
- ☐ Autologous BM re-infusion/boost *(no preparative treatment or conditioning)* GRAFAIBM
- ☐ Other: ..... GRFAIPB1 VTRENFA

GVHD

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD) AGVHGRMX

Maximum grade ☐ 0 (none) ☐ grade I ☐ grade II ☐ grade III ☐ grade IV ☐ Not evaluated

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

Stage:

Skin	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4 AGVHDSKI
Liver	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4 AGVHDLIV
Lower GI tract	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4 AGVHDLGI
Upper GI tract	☐ 0 (none)	☐ 1			AGVHDUGI

Other site affected ☐ No ☐ Yes AGVHOTHR

Resolution VGVHDRES

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

Treatment VTRAGVHD

☐ No

☐ Yes
- ☐ Corticosteroids
- ☐ MoAB: ..... VTRAGVH2 IDAABCCD
- ☐ ATG/ALG
- ☐ Extra-corporeal photopheresis (ECP) TRAGVHECP
- ☐ Other: ..... VAGVHDTO VAGVHDTR

TREATMENT DURING THE IMMEDIATE POST-TRANSPLANT PERIOD

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

- ☐ No VGRWFACT IDAABCCD
- ☐ Yes, specify ..... TRETSTAR Date started: .... - .... - ....
  yyyy mm dd
- ☐ Unknown

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

ADDITIONAL CELL INFUSIONS *(excluding a new HSCT)*

☐ No **VADCELLT**

☐ Yes: **BOOSTAL** 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.

BOOSTAU 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..... - ..... - ..... **IDAABC**
yyyy mm dd

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

Type of cell(s): *(check all that apply)* **VADLYMPH MESECHYM VADFIBRO VADDENDR**
☐ Lymphocyte *(DLI)* ☐ Mesenchymal ☐ Fibroblasts ☐ Dendritic cells
☐ NK cells ☐ Regulatory T-cells ☐ Gamma/delta cells ☐ Other, specify ....

NKCELLS RTCELLS GDCELLS VADOTHER VADCELLS

Number of cells infused by type	
NUCL1 Nucleated cells (/kg*) *(DLI only)*	.... - .... x 10^8 ☐ Not evaluated ☐ unknown
OTCLDS1 CD 34+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
CD3POSCL CD 3+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
Total number of cells infused	
ALLCELLS All cells (cells/kg*) *(non DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown

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

Indication: *(check all that apply)* **VREASDL1**
☐ Planned/protocol ☐ Treatment for disease
☐ Prophylactic ☐ Mixed chimaerism
☐ Treatment of GvHD ☐ Treatment viral infection
☐ Loss/decreased chimaerism
☐ Treatment PTLD, EBV lymphoma
☐ Other, specify .... **REASDLIO**

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

ADDITIONAL DISEASE TREATMENT ADDPROT

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

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

Chemo/drug VCHEMOTH
☐ No IDAABCCD
☐ 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, palifermin)
- ☐ 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 OTHECHEM ROUTADM

Radiotherapy VRADIOTH ☐ No ☐ Yes ☐ Unknown

Other type VOTHERT ☐ No ☐ Yes, specify …….. VOTHERTS ☐ 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 VCOMB100

☐ No complications
☐ Yes

Type INFECTIO	**Pathogen** *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.* PATHOGEN VOTHPATH	**Date** *Provide different dates for different episodes of the same complication if applicable.* IDAABE / BEGINFEP
Bacteraemia/ fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
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 VOTCO100

☐ No complications
☐ Yes

IDAABECA **Type** *(Check all that are applicable for this period)*	**Yes**	**No**	**Unknown**	**Date** IDAABE / DBEGCOM
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: ..... - ..... - ..... IDAABE
yyyy mm dd

OR

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

CHRONIC GRAFT VERSUS HOST DISEASE (CGVHD)

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

☐ No *(never)* GRAVHOSD

☐ Yes, first episode

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

Maximum extent during this period ☐ Limited ☐ Extensive ☐ Not evaluated VCGVHDG

Maximum NIH score during this period
☐ Mild ☐ Moderate ☐ Severe ☐ Not calculated MAXNIHSC

IDAABECK ORGANOTS DIFFUSIN

Organs affected ☐ Skin ☐ Liver ☐ Lower GI tract ☐ Upper GI tract
☐ Mouth ☐ Eyes ☐ Lung ☐ Other, specify .....
☐ Unknown

FIRST RELAPSE OF PROGRESSION VRELPROG

☐ No

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

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

Method of detection VRELLEUK		DHEMREL	**Site** VRELLEU2
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	..... - ..... - ..... DCYTREL yyyy mm dd	
VRELLEU3	☐ Yes: Date first seen	..... - ..... - ..... yyyy mm dd	☐ marrow – blood ☐ extramedullary
	☐ Not evaluated		VRELLEU4
VRELLEU5		DMOLREL	VRELLEU6
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 ..... - ..... - .....☐ Not evaluated yyyy mm dd
FILL IN ONLY FOR ACUTE AND CHRONIC LEUKAEMIAS Cytogenetic/FISH	☐ No ☐ Yes: Considered disease relapse/progression ☐ No ☐ Yes
DISCYT DISCYTDR DISCYTD	Last date assessed ..... - ..... - .....☐ Not evaluated yyyy mm dd
Molecular	☐ No ☐ Yes: Considered disease relapse/progression ☐ No ☐ Yes
DISMOL DISMOLDR DISMOLD	Last date assessed ..... - ..... - .....☐ Not evaluated yyyy mm dd

SURVIVAL STATUS AT 100 DAYS VPATSTAT

☐ Alive
☐ Dead

PERFORMANCE SCORE *(if alive)* PERFSYST

Type of score used ☐ Karnofsky ☐ LanskyPERFSYST

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

☐ 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)* VCAUSDTH

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

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

	(check as many as appropriate)	Yes	No	Unknown
VCSDTGVH	GvHD *(if previous allograft)*	☐	☐	☐
VCSDTINP	Interstitial pneumonitis	☐	☐	☐
VCSDTPTX	Pulmonary toxicity	☐	☐	☐
VCSDTINF	Infection	☐	☐	☐
VCSDTBAC	bacterial	☐	☐	☐
VCSDTVIR	viral	☐	☐	☐
VCSDTFUN	fungal	☐	☐	☐
VCSDTPAR	parasitic	☐	☐	☐
VCSDTREJ	Rejection / poor graft function	☐	☐	☐
VCSDTVOD	History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
VCSDTHMR	Haemorrhage	☐	☐	☐
VCSDTCTX	Cardiac toxicity	☐	☐	☐
VCSDTCNS	Central nervous system toxicity	☐	☐	☐
VCSDTGIT	Gastro intestinal toxicity	☐	☐	☐
VCSDTSKI	Skin toxicity	☐	☐	☐
VCSDTREN	Renal failure	☐	☐	☐
VCSDTMOF	Multiple organ failure	☐	☐	☐

Other: ..... DEACSBMR

COMMENTS COMMENT1/2/3

IDENTIFICATION & SIGNATURE

.....