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)*

HIV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
CMV	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
EBV	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
HBVs	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
HBVc	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
HBVe	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐Negative	☐Positive	☐Not evaluated	☐Unknown
HCV	☐Negative	☐Positive	☐Not evaluated	☐Unknown	☐ Negative	☐Positive	☐Not evaluated	☐Unknown
HTLV.I	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
Toxoplasmosis	☐Negative	☐Positive	☐Not evaluated	☐Unknown				
Other	☐Negative	☐Positive	Specify……					

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

☐ No

☐ Yes:

Candida	☐ Yes	☐ No	☐ Unknown
Aspergillus	☐ Yes	☐ No	☐ Unknown
Pneumocystis carinii	☐ Yes	☐ No	☐ Unknown
Other	☐ Yes	☐ No	If Yes, specify .....

☐ Unknown

PERFORMANCE SCORE

Type of score used ☐ Karnofsky ☐ Lansky

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

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

☐ Not evaluated

☐ Unknown

PATIENT WEIGHT (kg): .....

HEIGHT (cm): .....

COMORBIDITY INDEX

Sorror et al., Blood, 2005 Oct 15; 106(8): 2912-2919: *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1895304/*

Was there any ***clinically significant*** co-existing disease or organ impairment as listed below at time of patient assessment prior to the preparative regimen? ☐ No ☐ Yes, indicate each comorbidity below

Comorbidity	Definitions	No	Yes	Not evaluated
Solid tumour, previously present	Treated at any time point in the patient's past history, excluding non-melanoma skin cancer Indicate type ……	☐	☐	☐
Inflammatory bowel disease INBWDIS	Crohn's disease or ulcerative colitis	☐	☐	☐
Rheumatologic	SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica	☐	☐	☐
Infection INFECPRE	Requiring continuation of antimicrobial treatment after day 0	☐	☐	☐
Diabetes	Requiring treatment with insulin or oral hypoglycaemics but not diet alone	☐	☐	☐
Renal: moderate/severe KIDNEYCO	Serum creatinine > 2 mg/dL or >177 µmol/L, on dialysis, or prior renal transplantation	☐	☐	☐
Hepatic: mild	Chronic hepatitis, bilirubin between Upper Limit Normal (ULN) and 1.5 x the ULN, or AST/ALT between ULN and 2.5 × ULN	☐	☐	☐
moderate/ severe	Liver cirrhosis, bilirubin greater than 1.5 × ULN, or AST/ALT greater than 2.5 × ULN	☐	☐	☐
Arrhythmia	Atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias	☐	☐	☐
Cardiac CARDIAC	Coronary artery disease, congestive heart failure, myocardial infarction, EF ≤ 50%, or shortening fraction in children (<28%)	☐	☐	☐
Cerebrovascular disease	Transient ischemic attack or cerebrovascular accident	☐	☐	☐
Heart valve disease VALVE	Except mitral valve prolapse	☐	☐	☐
Pulmonary: moderate	DLco and/or FEV1 66-80% or dyspnoea on slight activity	☐	☐	☐
severe	DLco and/or FEV1 ≤ 65% or dyspnoea at rest or requiring oxygen	☐	☐	☐
Obesity	Patients with a body mass index > 35 kg/m2	☐	☐	☐
Peptic ulcer PEPTICU	Requiring treatment	☐	☐	☐
Psychiatric disturbance	Depression or anxiety requiring psychiatric consultation or treatment	☐	☐	☐

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

……

DONOR AND STEM CELL SOURCE

Multiple donors
(including multiple CB units)

☐ No
☐ Yes: Number of donors .....

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

DONOR 1

HLA MATCH TYPE *(DONOR RELATION WITH PATIENT)*

- ☐ 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
  ☐ >=2 HLA loci mismatch

Donor ID given by the centre .....

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	
	☐	☐	☐	☐	☐	☐	Antigenic
	☐	☐	☐	☐	☐	☐	Allelic

0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated

☐ Unrelated donor

GRID (Global Registration ID of the Donor) (*19 characters)* _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _
https://wmda.info/professionals/optimising-search-match-connect/why-global-identifier/

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

WMDA / BMDW code of the Donor Registry or Cord Blood Bank *(If ION code unknown. Up to 4 characters)* ....

Name of donor registry or Cord Blood Bank *(if above codes unknown)* .....

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

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

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

DONOR INFORMATION

Blood group: ☐ A ☐ B ☐ AB ☐ O

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

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

Sex: ☐ Male ☐ Female *(at birth)*

STATUS OF THE DONOR OR CORD BLOOD UNIT BEFORE HSCT

SEROLOGY				ANTIGENS *(if applicable)*
HIV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
CMV	☐ Negative	☐ Positive	☐ Not evaluated	
EBV	☐ Negative	☐ Positive	☐ Not evaluated	
HBVs	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HBVc	☐ Negative	☐ Positive	☐ Not evaluated	
HBVe	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HCV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HTLV.I	☐ Negative	☐ Positive	☐ Not evaluated	
Syphilis	☐ Negative	☐ Positive	☐ Not evaluated	
Toxoplasmosis	☐ Negative	☐ Positive	☐ Not evaluated	
Other	☐ Negative	☐ Positive	Specify……	

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

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

DONOR 1 – PRODUCT NUMBER 1

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

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: .....

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

Growth factors administered to the donor

☐ No ☐ 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:

- ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ Elutriation
- ☐ Other: .....

Positive ☐ No ☐ Yes:

- ☐ Monoclonal antibodies: CD34+ enrichment
  Other
- ☐ Other: .....

Expansion ☐ No ☐ Yes

Genetic manipulation ☐ No ☐ Yes

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)	.... -	☐	☐	☐	☐
CD 34+ (cells/kg)	.... -	☐	☐	☐	☐
T-cells (CD 3+) (cells/kg)	.... -	☐	☐	☐	☐

⇨ **(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

☐ Intravenous (IV) ☐ intrabone / intramedullary

☐ Other, specify: ..... ☐ unknown

Infusion method

☐ DMSO ☐ Wash (Rubinstein/New York)

☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on:

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used

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

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

Viability of all cells ..... %

Viability of CD34+ cells ..... %

DONOR 1 – PRODUCT NUMBER 2

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

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: .....

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

Growth factors administered to the donor

☐ No ☐ 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:

- ☐ T-cell (CD3+) depletion *(do not use for "Campath in bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ Elutriation
- ☐ Other: .....

Positive ☐ No ☐ Yes:

- ☐ Monoclonal antibodies: CD34+ enrichment
  Other
- ☐ Other: .....

Expansion ☐ No ☐ Yes

Genetic manipulation ☐ No ☐ Yes

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)	.... -	☐	☐	☐	☐
CD 34+ (cells/kg)	.... -	☐	☐	☐	☐
T-cells (CD 3+) (cells/kg)	.... -	☐	☐	☐	☐

⇨ **(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

☐ Intravenous (IV) ☐ intrabone / intramedullary

☐ Other, specify: ..... ☐ unknown

Infusion method

☐ DMSO ☐ Wash (Rubinstein/New York)

☐ Other, specify: .....

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on:

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used

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

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

Viability of all cells ..... %

Viability of CD34+ cells ..... %

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

DONOR 2

HLA MATCH TYPE *(DONOR RELATION WITH PATIENT)*

- ☐ 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
  ☐ >=2 HLA loci mismatch

Donor ID given by the centre .....

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	
☐	☐	☐	☐	☐	☐	Antigenic
☐	☐	☐	☐	☐	☐	Allelic

0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated

☐ Unrelated donor

GRID (Global Registration ID of the Donor) (*19 characters)* _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _
https://wmda.info/professionals/optimising-search-match-connect/why-global-identifier/

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

WMDA / BMDW code of the Donor Registry or Cord Blood Bank *(If ION code unknown. Up to 4 characters)* ....

Name of donor registry or Cord Blood Bank *(if above codes unknown)* .....

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

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

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

DONOR INFORMATION

Blood group: ☐ A ☐ B ☐ AB ☐ O

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

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

Sex: ☐ Male ☐ Female *(at birth)*

STATUS OF THE DONOR OR CORD BLOOD UNIT BEFORE HSCT

SEROLOGY				ANTIGENS *(if applicable)*
HIV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
CMV	☐ Negative	☐ Positive	☐ Not evaluated	
EBV	☐ Negative	☐ Positive	☐ Not evaluated	
HBVs	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HBVc	☐ Negative	☐ Positive	☐ Not evaluated	
HBVe	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HCV	☐ Negative	☐ Positive	☐ Not evaluated	☐ Negative ☐ Positive ☐ Not evaluated
HTLV.I	☐ Negative	☐ Positive	☐ Not evaluated	
Sy Philis	☐ Negative	☐ Positive	☐ Not evaluated	
Toxoplasmosis	☐ Negative	☐ Positive	☐ Not evaluated	
Other	☐ Negative	☐ Positive	Specify……	

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

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

DONOR 2 – PRODUCT NUMBER 1

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

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: .....

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

Growth factors administered to the donor

☐ No ☐ 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:

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

☐ Elutriation
☐ Other: .....

Positive: ☐ No ☐ Yes:

☐ CD34+ enrichment
☐ Monoclonal antibodies
☐ Other

Expansion ☐ No ☐ Yes

Genetic manipulation ☐ No ☐ Yes

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)	.... -	☐	☐	☐	☐
CD 34+ (cells/kg)	.... -	☐	☐	☐	☐
T-cells (CD 3+) (cells/kg)	.... -	☐	☐	☐	☐

⇨ **(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

☐ Intravenous (IV) ☐ intrabone / intramedullary
☐ Other, specify: ..... ☐ unknown

Infusion method

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

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on:

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used

☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide
☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... %

Viability of CD34+ cells ..... %

DONOR 2– PRODUCT NUMBER 2

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

☐ Bone Marrow ☐ Peripheral Blood

☐ Cord Blood ☐ Other: .....

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

Growth factors administered to the donor

☐ No ☐ 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:

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

☐ Elutriation
☐ Other: .....

Positive: ☐ No ☐ Yes:

☐ CD34+ enrichment
☐ Monoclonal antibodies
☐ Other

Expansion ☐ No ☐ Yes

Genetic manipulation ☐ No ☐ Yes

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)	.... -	☐	☐	☐	☐
CD 34+ (cells/kg)	.... -	☐	☐	☐	☐
T-cells (CD 3+) (cells/kg)	.... -	☐	☐	☐	☐

⇨ **(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

☐ Intravenous (IV) ☐ intrabone / intramedullary
☐ Other, specify: ..... ☐ unknown

Infusion method

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

CELL VIABILITY RESULTS AT HSCT CENTRE FOR THIS PRODUCT

Tests performed after thawing of an aliquot on:

☐ Contiguous segment ☐ Reference bag ☐ unknown

Method used

☐ 7-AAD ☐ Tryptan blue ☐ Acridine orange-ethidium iodide
☐ Acridine orange-ethidium bromide ☐ Other, specify ..... ☐ unknown

Viability of all cells ..... %

Viability of CD34+ cells ..... %

HSC TRANSPLANTATION

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

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

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

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

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

Name of the institution ……

City ……

⇨ If >1, please submit a **MED-A annual follow up** before proceeding, **giving the date of the subsequent transplant as the date of last contact**. This is so we can capture relapse data and other events between transplants.

HSCT part of a multiple graft protocol (program)?

☐ No
☐ Yes: Type of multiple graft protocol .....

Graft number in the protocol _____ out of _____ total number of HSCTs in the program

☐ Unknown

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

PREPARATIVE TREATMENT *(conditioning)*

PREPARATIVE (CONDITIONING) REGIMEN GIVEN

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

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

☐ Yes
☐ Unknown

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

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

Specification and dose of the preparative regimen

TOTAL PRESCRIBED CUMULATIVE DOSE*

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

DRUG (given before day 0)	DOSE	UNITS		Area under the curve (AUC)
☐ Ara-C *(cytarabine)*		☐ mg/m²	☐ mg/Kg	
☐ ALG, ATG Animal origin: ☐ Horse ☐ Rabbit ☐ Other, specify....		☐ mg/m²	☐ mg/Kg	
☐ Bleomycin		☐ mg/m²	☐ mg/Kg	
☐ Busulfan ☐ Oral ☐ IV ☐ Both		☐ mg/m²	☐ mg/Kg	☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL
☐ BCNU		☐ mg/m²	☐ mg/Kg	
☐ Bexxar *(radiolabelled MoAB)*		☐ mCi	☐ MBq	
☐ CCNU		☐ mg/m²	☐ mg/Kg	
☐ Campath *(antiCD52)*		☐ mg/m²	☐ mg/Kg	
☐ Carboplatin		☐ mg/m²	☐ mg/Kg	☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL
☐ Cisplatin		☐ mg/m²	☐ mg/Kg	
☐ Clofarabine		☐ mg/m²	☐ mg/Kg	
☐ Corticosteroids		☐ mg/m²	☐ mg/Kg	
☐ Cyclophosphamide		☐ mg/m²	☐ mg/Kg	
☐ Daunorubicin		☐ mg/m²	☐ mg/Kg	
☐ Doxorubicin *(adriamycine)*		☐ mg/m²	☐ mg/Kg	
☐ Epirubicin		☐ mg/m²	☐ mg/Kg	
☐ Etoposide *(VP16)*		☐ mg/m²	☐ mg/Kg	
☐ Fludarabine		☐ mg/m²	☐ mg/Kg	
☐ Gemtuzumab		☐ mg/m²	☐ mg/Kg	
☐ Idarubicin		☐ mg/m²	☐ mg/Kg	
☐ Ifosfamide		☐ mg/m²	☐ mg/Kg	
☐ Imatinib mesylate		☐ mg/m²	☐ mg/Kg	
☐ Melphalan		☐ mg/m²	☐ mg/Kg	
☐ Mitoxantrone		☐ mg/m²	☐ mg/Kg	
☐ Paclitaxel		☐ mg/m²	☐ mg/Kg	
☐ Rituximab *(mabthera, antiCD20)*		☐ mg/m²	☐ mg/Kg	
☐ Teniposide		☐ mg/m²	☐ mg/Kg	
☐ Thiotepa		☐ mg/m²	☐ mg/Kg	
☐ Treosulphan		☐ mg/m²	☐ mg/Kg	
☐ Zevalin *(radiolabelled MoAB)*		☐ mCi	☐ MBq	
☐ Other radiolabelled MoAB, specify		☐ mCi	☐ MBq	
☐ Other MoAB, specify ……		☐ mg/m²	☐ mg/Kg	
☐ Other, specify ……..		☐ mg/m²	☐ mg/Kg	

TBI ☐ No ☐ Yes ☐ Unknown

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

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

Local radiotherapy ☐ No ☐ Yes ☐ Unknown

GvHD PREVENTION IN THE RECIPIENT

☐ No

☐ Yes: ☐ Drugs *(Immunosuppressive chemo)*

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

☐ Extra-corporeal photopheresis (ECP)

☐ Other: .....

SURVIVAL STATUS ON DATE OF HSCT

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

Main Cause of Death *(check only one main cause)*:
☐ Relapse or Progression/Persistent disease ☐ HSCT Related Cause
☐ Unknown
☐ Other: .....

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

(check as many as appropriate)	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection	☐	☐	☐
bacterial	☐	☐	☐
viral	☐	☐	☐
fungal	☐	☐	☐
parasitic	☐	☐	☐
Rejection / poor graft function	☐	☐	☐
History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
Haemorrhage	☐	☐	☐
Cardiac toxicity	☐	☐	☐
Central nervous system toxicity	☐	☐	☐
Gastro intestinal toxicity	☐	☐	☐
Skin toxicity	☐	☐	☐
Renal failure	☐	☐	☐
Multiple organ failure	☐	☐	☐

Other: .....

ADDITIONAL NOTES IF APPLICABLE

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

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

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

Hospital Unique Patient Number .....

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

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

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

RECOVERY and GRAFT PERFORMANCE

Absolute neutrophil count (ANC) recovery *(Neutrophils ≥0.5X10^9 /L)*
☐ No: Date of last assessment: ..... - ..... - .....
yyyy mm dd
☐ Yes: Date of ANC recovery: ..... - ..... - ..... *(first of 3 consecutive values after 7 days without transfusion containing neutrophils)*
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 ..... - ..... - .....
yyyy mm dd
☐ Never below this level
☐ Date unknown: patient discharged before levels reached
☐ Date unknown: out-patient
☐ Unknown

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

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

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

HAEMOPOIETIC CHIMAERISM

Overall chimaerism
- ☐ Full *(donor ≥95 %)*
- ☐ Mixed *(partial)*
- ☐ Patient reconstitution *(recipient ≥95 %)*
- ☐ Aplasia
- ☐ Not informative
- ☐ 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

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

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

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

GVHD

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

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

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

Stage:

Skin	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Liver	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Lower GI tract	☐ 0 (none)	☐ 1	☐ 2	☐ 3	☐ 4
Upper GI tract	☐ 0 (none)	☐ 1			

Other site affected ☐ No ☐ Yes

Resolution

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

Treatment

☐ No

☐ Yes
- ☐ Corticosteroids
- ☐ MoAB: .....
- ☐ ATG/ALG
- ☐ Extra-corporeal photopheresis (ECP)
- ☐ Other: .....

TREATMENT DURING THE IMMEDIATE POST-TRANSPLANT PERIOD

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

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

ADDITIONAL CELL INFUSIONS *(excluding a new HSCT)*

☐ No

☐ Yes: Is this cell infusion an allogeneic boost? ☐ No ☐ Yes – *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.

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..... - ..... - .....
yyyy mm dd

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

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

Number of cells infused by type	
Nucleated cells (/kg*) *(DLI only)*	.... - .... 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 the cell infusion episode for this patient .....

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

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

ADDITIONAL DISEASE TREATMENT

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

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

Chemo/drug
☐ No
☐ Yes:
☐ Anti-lymphocyte antibodies
☐ Azacytidine
☐ Azathioprine
☐ Bortezomib (Velcade)
☐ Cop-I
☐ Corticosteroids
☐ Crenolanib
☐ Cyclophosphamide
☐ Dasatinib (Sprycel)
☐ Decitabine
☐ Eculizumab (Soliris)
☐ Imatinib mesylate (Gleevec, Glivec)
☐ Interferon α
☐ Interferon β
☐ Kepivance (KGF, 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

Radiotherapy ☐ No ☐ Yes ☐ Unknown

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

COMPLICATIONS WITHIN THE FIRST 100 DAYS.

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

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

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

☐ No complications
☐ Yes

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

yyyy mm dd

LAST CONTACT DATE FOR 100 DAY ASSESSMENT

*If patient has died **before** this date, enter date of death, otherwise enter Date of HSCT + 100 DAYS APPROX.*

Day 100 assessment: ..... - ..... - .....
yyyy mm dd

OR

Date of death (if before day 100): ..... - ..... - .....
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)*

☐ Yes, first episode

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

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

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

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

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

FIRST RELAPSE OF PROGRESSION

☐ No

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

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

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

☐ Continuous progression since transplant

☐ Unknown

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

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

☐ Alive
☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

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

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

☐ Not evaluated

MAIN CAUSE OF DEATH *(if dead)*

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

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

(check as many as appropriate)	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection	☐	☐	☐
bacterial	☐	☐	☐
viral	☐	☐	☐
fungal	☐	☐	☐
parasitic	☐	☐	☐
Rejection / poor graft function	☐	☐	☐
History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
Haemorrhage	☐	☐	☐
Cardiac toxicity	☐	☐	☐
Central nervous system toxicity	☐	☐	☐
Gastro intestinal toxicity	☐	☐	☐
Skin toxicity	☐	☐	☐
Renal failure	☐	☐	☐
Multiple organ failure	☐	☐	☐

Other: .....

COMMENTS .....

IDENTIFICATION & SIGNATURE

.....