EBMT Centre Identification Code (CIC): _ _ _ _
Hospital Unique Patient Number (UPN): _ _ _ _ _ _ _ _ _ _ _ _
Patient Number in EBMT database: _ _ _ _ _ _ _ _ _

Treatment Type ☐ HCT

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

# ALLOGENEIC HAEMATOPOIETIC CELL TRANSPLANTATION (HCT)
# Day 0

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

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

**Survival status at HCT:**

☐ Alive

☐ Died after conditioning but before HCT

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

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

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

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

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

**If > 1:**

**Reason for this HCT:**

☐ Indication diagnosis

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

☐ Complication after previous treatment (HCT/CT)

☐ Primary graft failure

☐ Secondary graft failure

☐ Secondary malignancy

☐ Other; specify: _____

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

**Type of the last treatment before this one:**

☐ Autologous HCT

☐ Allogeneic HCT

☐ Cellular therapy

**Was the last treatment performed at another institution?**

☐ No

☐ Yes: CIC (if known): _____

Name of institution: _____

City: _____

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

## DONOR & GRAFT INFORMATION

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

☐ No

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

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

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

☐ No

☐ Yes: Number of donors: _____

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

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

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

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

☐ Yes

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

*(year of birth is a mandatory field)*

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

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

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

☐ Male

☐ Female

**Donor Identification:**

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

Global registration identifier for donors (GRID): _____

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

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

Name of Donor Registry or Cord Blood Bank: _____

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

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

***Donor EBV status:**

☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

***Donor CMV status:**

☐ Negative
☐ Positive
☐ Not evaluated
☐ Unknown

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

☐ No

☐ Yes

**Did this donor provide more than one stem cell product:**

☐ No

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

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

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

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

### *Donor __(number) - Product Number 1

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

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

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

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

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

### *Donor __(number) - Product Number 2

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

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

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

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

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

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

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

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

☐ *Related donor, type:

☐ *Match (both haplotypes matched)

☐ *Mismatch:

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

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

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

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

☐ A ☐ DRB1
☐ B ☐ DQB1
☐ C ☐ DPB1

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

☐ No
☐ Yes
☐ Unknown

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

☐ Syngeneic (monozygotic twin) (*option only for matched related donors*)

☐ Sibling *(may include non-monozygotic twin)*

☐ Other related:
- ☐ Parents
- ☐ Child
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grand Parents
- ☐ Other; specify: _____

☐ *Unrelated donor:

***Degree of HLA matching:**

☐ Full match (10/10)

☐ Single HLA mismatch (9/10)

☐ >=2 HLA mismatches (<9/10)

**HLA-DPB1 matching:**

☐ Match ☐ At least 1 mismatch ☐ Not typed

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

☐ A ☐ DRB1
☐ B ☐ DQB1
☐ C ☐ DPB1

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

## ADDITIONAL ASSESSMENTS
(All diagnoses)

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

☐ No

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

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

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

☐ Not evaluated

☐ Unknown

## PATIENT SEROLOGICAL STATUS
(All diagnoses)

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

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

## PREPARATIVE REGIMEN
(All Diagnoses)

**Preparative (conditioning) regimen given?**

☐ No *(Primary Immunodeficiency Disorders only)*

☐ Yes

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

☐ No

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

**What type of conditioning regimen was used?**

☐ Reduced intensity conditioning (RIC)

☐ Myeloablative conditioning (MAC)

## PREPARATIVE REGIMEN continued

**Specification and dose of the preparative regimen:**

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

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

## PREPARATIVE REGIMEN continued

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

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

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

**Total body irradiation (TBI):**

☐ No

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

Number of fractions: _____

Number of radiation days: _____

## GvHD PROPHYLAXIS

**GvHD prophylaxis or preventive treatment:**

☐ No

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

☐ Extracorporeal photopheresis (ECP)

☐ Other; specify: _____

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

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