



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

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

AUTOLOGOUS 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 autologous HCT: _____
 (all autologous 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.



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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:** _____

Source of stem cells:

(check all that apply)

- Bone marrow
- Peripheral blood
- Cord blood
- Other; specify: _____

Graft manipulation ex-vivo:

(other than for gene therapy, RBC removal or volume reduction)

- No
- Yes: CD34+ manipulation
- Other manipulation; specify: _____



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MOBILISATION
Autoimmune Diseases only

Mobilisation drugs given?

No

Yes; Start date of mobilisation: ____/____/____ (YYYY/MM/DD)

Cyclophosphamide: No Yes Dose: _____ g/m²

Corticosteroids: No Yes Daily dose: _____ mg/kg

G-CSF: No Yes

Plerixafor: No Yes

Other; specify*: _____

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

PREPARATIVE REGIMEN
 (All Diagnoses)

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

- No *(usually paediatric inherited disorders only)*
- Yes *(provide details on pages 4-5)*

Autoimmune diseases only:

Serotherapy given? *(ATG, ALG, alemtuzumab)*

- No
- Yes *(provide details in the table on pages 4-5)*



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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
<input type="checkbox"/> Alemtuzumab	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Anti-Thymocyte Globulin Anti-Lymphocyte Globulin Product name: _____ Origin: <input type="checkbox"/> Rabbit <input type="checkbox"/> Horse <input type="checkbox"/> Other; specify: _____	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Bendamustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Bleomycin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Busulfan Route of administration: <input type="checkbox"/> Oral <input type="checkbox"/> IV <input type="checkbox"/> Both Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carboplatin Drug monitoring performed: <input type="checkbox"/> No <input type="checkbox"/> Yes; total AUC: _____ <input type="checkbox"/> mg x hr/L <input type="checkbox"/> micromol x min/L <input type="checkbox"/> mg x min/mL	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Carmustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cisplatin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Clofarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
Corticosteroids:		
<input type="checkbox"/> Beclometasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Budesonide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Dexamethasone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Methylprednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Prednisolone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Cyclophosphamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> 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
<input type="checkbox"/> Cytarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Daunorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Doxorubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Epirubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Etoposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Fludarabine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Gemtuzumab ozogamicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Ibritumomab tiuxetan	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Idarubicin	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Ifosfamide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Imatinib	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Lomustine	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Melphalan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Mitoxantrone	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Paclitaxel	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Rituximab	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Teniposide	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Thiotepa	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Tositumomab	_____	<input type="checkbox"/> mCi <input type="checkbox"/> MBq
<input type="checkbox"/> Treosulfan	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg
<input type="checkbox"/> Other; specify*: _____	_____	<input type="checkbox"/> mg/m ² <input type="checkbox"/> mg/kg <input type="checkbox"/> mCi <input type="checkbox"/> MBq

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Total body irradiation (TBI):

- No
- Yes; Total prescribed radiation dose as per protocol: _____ Gy
- Number of fractions: _____
- Number of radiation days: _____