



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

Treatment Type HCT CT IST Other
Treatment Date ____/____/____ (YYYY/MM/DD)

HAEMOGLOBINOPATHIES

DISEASE

Note: complete this form only if this diagnosis was the indication for the HCT/CT or if it was specifically requested. Consult the manual for further information.

Date of diagnosis/date of first event: ____/____/____ (YYYY/MM/DD)

Classification:

Thalassaemia

Beta 0

Beta+

Beta E

Beta S (sickle cell + thalassaemia): Percentage sickle cell: _____ %

Thalassaemia genotype: _____

Sickle cell disease

SS

SC

SB+

SB 0

Other; specify: _____

Other haemoglobinopathy; specify: _____