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IMMUNOSUPPRESSIVE TREATMENT (IST)
Day 0

This form should be filled in for each individual immunosuppressive treatment episode.

Date this IST episode started: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* **Center where treatment took place (CIC):** ____

Indication diagnosis for this IST episode:_____
(make sure you registered indication diagnosis using relevant diagnosis form first)

Total number of all treatments: _____
(including all types of treatments for this patient, e.g. HCT, CT or IST)

Reason for this IST episode:

- ☐ Indication diagnosis
- ☐ Failure of first line therapy
- ☐ Relapse
- ☐ PR to previous treatment
- ☐ Other; specify: _____
- ☐ Unknown

Chronological number of this IST episode: _____

Ferritin level: _____ **ng/ml** ☐ Not evaluated ☐ Unknown

Complete this section only if this is the first IST episode ever for this patient:

Number of transfusions before the 1st IST episode:

RBC:
- ☐ < 20 units
- ☐ 20 - 50 units
- ☐ > 50 units
- ☐ None
- ☐ Unknown

RBC irradiated:
- ☐ No
- ☐ Yes
- ☐ Unknown

Platelets:
- ☐ < 20 units
- ☐ 20 - 50 units
- ☐ > 50 units
- ☐ None
- ☐ Unknown

Platelets irradiated:
- ☐ No
- ☐ Yes
- ☐ Unknown

IMMUNOSUPPRESSION

Drugs used for immunosuppression during this IST episode (check at least one)**:**

Drug	**Date started** *(YYYY/MM/DD)*	**Date ended (***YYYY/MM/DD)*
☐ Alemtuzumab	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Anti-Thymocyte Globulin Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
Corticosteroids:		
☐ Beclometasone	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Budesonide	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Dexamethasone	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Methylprednisolone	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Prednisolone	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Cyclophosphamide	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Cyclosporine	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Filgrastim	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Lenograstim	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Pegfilgrastim	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Mycophenolate mofetil	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Rituximab	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _
☐ Other; specify*: _____	_ _ _ _ / _ _ / _ _	_ _ _ _ / _ _ / _ _

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