



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

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)

Centre where this HCT took place: _____

Patient UPN for this treatment: _____

Team or unit where treatment took place (select all that apply):

- Adults Pediatrics Haematology Oncology Allograft Autograft Other; specify: _____

Unit number: _____ Not applicable

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, GT, 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/GT/IST)
- Complication after previous treatment (HCT/CT/GT/IST)
- 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 (CT)
- Immunosuppressive treatment (IST)
- Gene therapy (GT)

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

DONOR & GRAFT INFORMATION

Is this HCT part of a (planned) 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 2 years)

***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 blood group:**

- A
 B
 AB
 O

***Donor rhesus factor:**

- Negative
 Positive

***Donor EBV status:**

- Negative
 Positive
 Not evaluated
 Unknown

***Donor CMV status:**

- Negative
 Positive
 Not evaluated
 Unknown

***Is donor heterozygous?** *(Sickle cell disease only)*

- No
 Yes

***Is donor a carrier for X-linked disease?** *(Inborn Errors 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:** Bone Marrow
 (select only one) Peripheral Blood
 Cord Blood
 Other; specify: _____

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

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

***Was the graft cryopreserved prior to infusion?**

- No
 Yes; *Date of cryopreservation: ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

***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:** Bone Marrow
 (select only one) Peripheral Blood
 Cord Blood
 Other; specify: _____

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

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

***Was the graft cryopreserved prior to infusion?**

- No
 Yes; *Date of cryopreservation: ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

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.

***Relation between patient and donor:** Related:

- Relationship to patient:** Syngeneic (monozygotic twin)
 Sibling (may include non-monozygotic twin)
 Other related: Parents
 Child
 Aunt/Uncle
 Cousin
 Grand Parents
 Other; specify: _____

Unrelated (proceed to next page)

Related donor:

- *Both haplotypes confirmed by family studies?** No
 (for both matched and mismatched related donors) Yes
 Unknown

***HLA match type:**

*Match (both haplotypes matched)

*Mismatch: ***Method used for patient/donor HLA typing:** Molecular
 (select all that apply) Serology

if molecular typing was done:

*Locus:	*Number of mismatches, allelic:			
A:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated

if serological typing was done:

*Locus:	*Number of mismatches, antigenic:			
A:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated

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

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.

Unrelated donor:

***HLA match type:**

***Method used for patient/donor HLA typing:** Molecular
 (select all that apply) Serology

if molecular typing was done:

*Locus:	*Number of mismatches, allelic:			
A:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated

if serological typing was done:

*Locus:	*Number of mismatches, antigenic:			
A:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
B:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
C:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DRB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DQB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated
DPB1:	<input type="checkbox"/> 0 (match)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> Not evaluated

****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 DRB1
 B DQB1
 C 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

PREPARATIVE REGIMEN

(All Diagnoses)

Preparative (conditioning) regimen given?

- No
 Yes

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

- No
 Yes (provide details in the table on pages 8-9)

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. Report dosages and units only for individual drugs.)

Chemotherapy	Dose	Unit
<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
<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

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"/> 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"/> Anti-CD20 antibodies	_____	<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

*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:** _____

Total lymphatic irradiation (TLI):

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

Total abdominal irradiation (TAI):

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



EBMT Centre Identification Code (CIC): _____

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

Treatment Type HCT

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

GvHD PREVENTIVE TREATMENT

GvHD preventive treatment:

- No
- Yes: indicate the drugs

<input type="checkbox"/> Abatacept
<input type="checkbox"/> Alemtuzumab
<input type="checkbox"/> Anti-Thymocyte Globulin (ATG) Anti-Lymphocyte Globulin Product name: _____ Origin: <input type="checkbox"/> Rabbit Anti-Thymocyte Globulin (ATG) total cumulative dose (mg/kg): _____ <input type="checkbox"/> Horse <input type="checkbox"/> Unknown <input type="checkbox"/> Other; specify: _____
<input type="checkbox"/> Basiliximab
Corticosteroids: <input type="checkbox"/> Beclometasone <input type="checkbox"/> Budesonide <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Prednisolone
<input type="checkbox"/> Cyclophosphamide Post Transplant Cyclophosphamide (PTCY) cumulative dose (mg/kg): _____ <input type="checkbox"/> Unknown Post Transplant Cyclophosphamide (PTCY) timing schedule: <input type="checkbox"/> Single dose on day 3 <input type="checkbox"/> Single dose on day 5 <input type="checkbox"/> Doses on days 3 and 4 <input type="checkbox"/> Doses on days 3 and 5 <input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Cyclosporine
<input type="checkbox"/> Etanercept
<input type="checkbox"/> Everolimus
<input type="checkbox"/> Infliximab
<input type="checkbox"/> Methotrexate
<input type="checkbox"/> Mycophenolate mofetil
<input type="checkbox"/> Ruxolitinib
<input type="checkbox"/> Sirolimus
<input type="checkbox"/> Tacrolimus
<input type="checkbox"/> Other agent (in vivo); specify*: _____

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

END OF THE ALLO-HCT DAY 0 REPORT
proceed to form DISEASE STATUS AT HCT/CT/GT/IST