



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

Treatment Type HSCT CT OTHER
 Treatment Date ____/____/____ (YYYY/MM/DD)

ANONYMOUS EVENTS

DIAGNOSIS Main Classification

Year of diagnosis: ____

- Diagnosis classification:**
- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Acute leukemia | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Other |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> MDS | |
| <input type="checkbox"/> Bone marrow failure | <input type="checkbox"/> MDS/MPN | |
| <input type="checkbox"/> Chronic leukemia | <input type="checkbox"/> MPN | |
| <input type="checkbox"/> Haemoglobinopathy | <input type="checkbox"/> Plasma cell neoplasms | |
| <input type="checkbox"/> Inborn error | <input type="checkbox"/> Solid tumour | |

DIAGNOSIS Subclassification

ACUTE LEUKEMIA

Classification:

- | |
|---|
| <input type="checkbox"/> Acute myeloid leukaemia (AML) |
| <input type="checkbox"/> Precursor lymphoid neoplasms (ALL) |
| <input type="checkbox"/> Other acute leukaemia |

AUTOIMMUNE DISORDERS

Classification:

- Multiple sclerosis (MS)
 Systemic sclerosis (SSc)
 Other

BONE MARROW FAILURES

Classification:

- Severe aplastic anemia
 Other



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CHRONIC LEUKAEMIAS

Classification:

- Chronic myeloid leukaemia (CML)
- Chronic lymphocytic leukaemia (CLL)
- Other

HAEMOGLOBINOPATHIES

Classification:

- Thalassemia
- Sickle cell disease
- Other

INBORN ERRORS

Classification:

- Inborn error of immunity
- Inborn error of metabolism
- Other

LYMPHOMAS

Classification:

- B-cell non-Hodgkin lymphoma (NHL)
- T-cell non-Hodgkin lymphoma (NHL)
- Immunodeficiency-associated lymphoproliferative disorder (incl. PTLD)
- Other

PLASMA CELL DISORDERS

Classification:

- Multiple myeloma
- Other plasma cell disorder



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SOLID TUMOURS

Classification:

- Neuroblastoma
- Soft tissue/Ewing sarcoma
- Germ cell tumour
- Other solid tumour



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TREATMENT

Year of treatment: _____

Chronological number of this treatment: __

Age category at treatment: Pediatric Adult

Type of treatment:	<input type="checkbox"/> HCT	Type: <input type="checkbox"/> Autologous <input type="checkbox"/> Allogeneic	Cell source: <input type="checkbox"/> Peripheral blood <input type="checkbox"/> Cord blood <input type="checkbox"/> Bone marrow
	<input type="checkbox"/> CT	Source of cells: <input type="checkbox"/> Autologous <input type="checkbox"/> Allogeneic	
	<input type="checkbox"/> IST		
	<input type="checkbox"/> GT		