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

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)

Centre where this HCT took place (CIC): _____

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)

Extended dataset

Only for Chronic Myeloid Leukaemia (CML) patients

Reason for HCT (select as many reasons as applicable):

☐ Accelerated phase
☐ Blast crisis
☐ TKI intolerance
☐ Imatinib resistance
☐ Dasatinib resistance
☐ Nilotinib resistance
☐ Asciminib resistance
☐ Ponatinib resistance
☐ Bosutinib resistance
☐ Clonal evolution
☐ Poor risk patient or high risk CML
☐ ABL mutation
☐ Standard indication at diagnosis
☐ No engraftment/graft loss
☐ Clinical study
☐ Other, specify : _____
☐ Unknown

Chronological number of this treatment: _____
(Include *all types of treatments for this patient, e.g. HCT, CT, GT, IST*)

Chronological number of this HCT: _____
(Include *all HCTs this patient received in the past*)

Chronological number of this autologous HCT: _____
(Include *all autologous HCTs this patient received in the past*)

AUTOLOGOUS HAEMATOPOIETIC CELL TRANSPLANTATION (HCT)
Day 0

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.

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:** _____

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+ enrichment

☐ Other manipulation; specify: _____

Was the graft cryopreserved prior to infusion?

☐ No

☐ Yes

☐ Unknown

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

Extended dataset

MOBILISATION
All diagnoses except Autoimmune Diseases

Number of mobilisations: _____ ☐ Unknown

	Start date of mobilisation *(YYYY/MM/DD)*	**Drugs given at mobilisation** (select from the EBMT Drugs list)
Mobilisation 1	_ _ _ _ / _ _ / _ _ ☐ Unknown	
Mobilisation 2	_ _ _ _ / _ _ / _ _ ☐ Unknown	
Mobilisation 3	_ _ _ _ / _ _ / _ _ ☐ Unknown	

Infused cells counts per product

Source of cells for this product: ☐ Bone marrow ☐ Peripheral blood ☐ Cord blood ☐ Other, specify_____

Cell counts for this cell product:

*Cell type	*Counts	*Units
Nucleated cells (/kg)	_____ ☐ Not evaluated ☐ Unknown	☐ x10^6/kg ☐ x10^7/kg ☐ x10^8/kg
CD34+ cells (/kg)	_____ ☐ Not evaluated ☐ Unknown	☐ x10^5/kg ☐ x10^6/kg
CD3+ cells (/kg)	_____ ☐ Not evaluated ☐ Unknown	☐ x10^5/kg ☐ x10^6/kg ☐ x10^7/kg ☐ x10^8/kg

If products from different sources were infused, copy and fill-in this table as many times as necessary per each source of cells.

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?

☐ No

☐ Yes :
- ☐ **Alemtuzumab**
- ☐ **Rituximab**
- ☐ **ATG**
- ☐ **Other serotherapy; specify:** _____

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	Unit
☐ Alemtuzumab	_____	☐ mg/m² ☐ mg/kg
☐ Anti-Thymocyte Globulin|Anti-Lymphocyte Globulin Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____	_____	☐ mg/m² ☐ mg/kg
☐ Bendamustine	_____	☐ mg/m² ☐ mg/kg
☐ Bleomycin	_____	☐ mg/m² ☐ mg/kg
☐ Busulfan Route of administration: ☐ Oral ☐ IV ☐ Both Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carboplatin Drug monitoring performed: ☐ No ☐ Yes; total AUC: _____ ☐ mg x hr/L ☐ micromol x min/L ☐ mg x min/mL	_____	☐ mg/m² ☐ mg/kg
☐ Carmustine	_____	☐ mg/m² ☐ mg/kg
☐ Cisplatin	_____	☐ mg/m² ☐ mg/kg
☐ Clofarabine	_____	☐ mg/m² ☐ mg/kg
Corticosteroids:		
☐ Beclometasone	_____	☐ mg/m² ☐ mg/kg
☐ Budesonide	_____	☐ mg/m² ☐ mg/kg
☐ Dexamethasone	_____	☐ mg/m² ☐ mg/kg
☐ Methylprednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Prednisolone	_____	☐ mg/m² ☐ mg/kg
☐ Cyclophosphamide	_____	☐ mg/m² ☐ 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.
Report dosages and units only for individual drugs.)

Chemotherapy	Dose	Units
☐ Cytarabine	_____	☐ mg/m² ☐ mg/kg
☐ Daunorubicin	_____	☐ mg/m² ☐ mg/kg
☐ Doxorubicin	_____	☐ mg/m² ☐ mg/kg
☐ Epirubicin	_____	☐ mg/m² ☐ mg/kg
☐ Etoposide	_____	☐ mg/m² ☐ mg/kg
☐ Fludarabine	_____	☐ mg/m² ☐ mg/kg
☐ Gemtuzumab ozogamicin	_____	☐ mg/m² ☐ mg/kg
☐ Ibritumomab tiuxetan	_____	☐ mCi ☐ MBq
☐ Idarubicin	_____	☐ mg/m² ☐ mg/kg
☐ Ifosfamide	_____	☐ mg/m² ☐ mg/kg
☐ Imatinib	_____	☐ mg/m² ☐ mg/kg
☐ Lomustine	_____	☐ mg/m² ☐ mg/kg
☐ Melphalan	_____	☐ mg/m² ☐ mg/kg
☐ Mitoxantrone	_____	☐ mg/m² ☐ mg/kg
☐ Paclitaxel	_____	☐ mg/m² ☐ mg/kg
☐ Anti-CD20 antibodies	_____	☐ mg/m² ☐ mg/kg
☐ Teniposide	_____	☐ mg/m² ☐ mg/kg
☐ Thiotepa	_____	☐ mg/m² ☐ mg/kg
☐ Tositumomab	_____	☐ mCi ☐ MBq
☐ Treosulfan	_____	☐ mg/m² ☐ mg/kg
☐ Other; specify*: _____	_____	☐ mg/m² ☐ mg/kg ☐ mCi ☐ 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: _____

END OF THE AUTO-HCT DAY 0 REPORT

proceed to form DISEASE STATUS AT HCT/CT/GT/IST