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

Treatment Type ☐ HCT ☐ CT ☐ GT ☐ IST ☐ Other

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

MYELOPROLIFERATIVE NEOPLASMS (MPN)

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: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

Classification (WHO 2022):

☐ Primary myelofibrosis
☐ Polycythaemia vera (PV)
☐ Essential or primary thrombocythaemia (ET)
☐ Juvenile myelomonocytic leukaemia (JCMMoL, JMML, JCML, JCMML)
☐ Hyper eosinophilic syndrome (HES)
☐ Chronic eosinophilic leukaemia (CEL)
☐ Chronic neutrophilic leukaemia (CNL)
☐ Aggressive systemic mastocytosis
☐ Systemic mastocytosis with an associated haematologic neoplasm (SM-AHN)
☐ Mast cell leukaemia
☐ Mast cell sarcoma
☐ MLN-TK with FGFR1 rearrangement
☐ MLN-TK with PDGFRA rearrangement
☐ MLN-TK with PDGFRB rearrangement
☐ MLN-TK with JAK2 rearrangement
☐ MLN-TK with FLT3 rearrangement
☐ MLN-TK with ETV6::ABL1 fusion
☐ MPN not otherwise specified (NOS)
☐ Other; specify: _____

Therapy-related MPN:
(Secondary origin)

☐ No

☐ Yes, disease related to prior exposure to therapeutic drugs or radiation

☐ Unknown

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

Treatment Type ☐ HCT ☐ CT ☐ GT ☐ IST ☐ Other

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

MPN ASSESSMENTS

(Palpable) spleen size: _____ cm (below costal margin) ☐ Not evaluated ☐ Unknown

Spleen span on ultrasound or CT scan: _____ cm (maximum diameter) ☐ Not evaluated ☐ Unknown

Transfusion dependency:
☐ No
☐ Yes
☐ Unknown

Bone marrow fibrosis:
☐ Grade 0
☐ Grade 1
☐ Grade 2
☐ Grade 3
☐ Not evaluated
☐ Unknown

Blast count *(peripheral blood)***:** _____ % ☐ Not evaluated ☐ Unknown

---

Extended dataset

Assessments at diagnosis

Haematological values:

Peripheral blood

Haemoglobin (g/dL):_____	☐ Not evaluated	☐ Unknown
Platelets (10^9/L):_____	☐ Not evaluated	☐ Unknown
White Blood Cells (10^9/L):_____	☐ Not evaluated	☐ Unknown
% monocytes:_____	☐ Not evaluated	☐ Unknown
% neutrophils:_____	☐ Not evaluated	☐ Unknown

Bone marrow

% blasts:_____	If the precise blast count is not available, please indicate whether it is: ☐ ≤ 5%　　　☐ > 5%	☐ Not evaluated ☐ Unknown

Constitutional symptoms:

Constitutional symptoms	☐ No　　☐ Yes　　☐ Unknown

MPN ASSESSMENTS

Myelofibrosis only:

IPSS:

☐ Low risk

☐ Intermediate-1

☐ Intermediate-2

☐ High risk

☐ Not evaluated

☐ Unknown

DIPSS:

☐ Low risk

☐ Intermediate-1

☐ Intermediate-2

☐ High risk

☐ Not evaluated

☐ Unknown

MIPSS70:

☐ Low risk
☐ Intermediate
☐ High risk
☐ Not evaluated
☐ Unknown

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

Treatment Type ☐ HCT ☐ CT ☐ GT ☐ IST ☐ Other

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

CHROMOSOME ANALYSIS

Describe results of all the analyses done before HCT/CT/IST treatment

Chromosome analysis done before HCT/CT/IST treatment:

☐ No

☐ Yes: **Output of analysis:** ☐ Separate abnormalities   ☐ Full karyotype

☐ Unknown

Copy and fill-in this section as often as necessary.

If chromosome analysis was done:

What were the results?

☐ Normal

☐ Abnormal: number of abnormalities present: _____

☐ Failed

Date of chromosome analysis: _ _ _ _ / _ _ / _ _ (YYYY/MM/DD)   ☐ Unknown

For abnormal results, indicate below whether the abnormalities were absent, present or not evaluated.

abn 1 type; specify: _____	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
abn 5 type; specify: _____	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
abn 7 type; specify: _____	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
Trisomy 8	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
Trisomy 9	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
del(20q)	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
del(13q)	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
Other; specify: _____	☐ Absent	☐ Present		

OR

Transcribe the complete karyotype: _____

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

Treatment Type ☐ HCT ☐ CT ☐ GT ☐ IST ☐ Other

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

MOLECULAR MARKER ANALYSIS

Molecular marker analysis done before HCT/CT/IST treatment:

☐ No

☐ Yes

☐ Unknown

Copy and fill-in this section as often as necessary.
If molecular marker analysis was done:

Date of molecular marker analysis: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* ☐ Unknown

Indicate below whether the markers were absent, present or not evaluated.

ASXL1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
BCR::ABL1; *Molecular product of t(9;22)(q34;q11.2)*	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
CALR	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
		If present: ☐ Type 1 ☐ Type 2 ☐ Type 1 like ☐ Type 2 like ☐ Unknown		
CBL	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
cMPL	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
CSF3R	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
CUX1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
DDX41	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
ETV6	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
EZH2	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
IDH1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
IDH2	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
JAK2	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
KRAS	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
NRAS	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
PTEN	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
PTPN-11	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
RUNX1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
SF3B1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
SRSF2	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
TET2	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
TP53	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
	TP53 mutation type: ☐ Single hit ☐ Multi hit ☐ Unknown			
U2AF1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
UBA1	☐ Absent	☐ Present	☐ Not evaluated	☐ Unknown
Other; specify: _____	☐ Absent	☐ Present		

EBMT Centre Identification Code (CIC): _ _ _ _

Hospital Unique Patient Number (UPN): _ _ _ _ _ _ _ _ _ _ _ _

Patient Number in EBMT Registry: _ _ _ _ _ _ _ _ _

Treatment Type ☐ HCT ☐ CT ☐ GT ☐ IST ☐ Other

Treatment Date _ _ _ _/ _ _/ _ _ *(YYYY/MM/DD)*

Extended dataset

PREVIOUS THERAPIES
(between diagnosis and HCT/CT)

Previous therapy lines before the HCT/CT:

☐ No

☐ Yes: **complete the "Treatment — non-HCT/CT/GT/IST" form**

☐ Unknown