



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)

PATIENT REGISTRATION

INFORMED CONSENT

Did the patient consent to having their data submitted to EBMT?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
First informed consent date: ____/____/____ (YYYY/MM/DD)		
Most recent consent date: ____/____/____ (YYYY/MM/DD)		
Did the patient consent to data sharing with health authorities and/or researchers?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Did the patient consent to data sharing with HTA bodies/reimbursement agencies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Did the patient consent to data sharing with Market Authorisation Holders (MAH)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Did the patient consent to their medical records being reviewed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown

PATIENT DATA

Hospital Unique Patient Number or code (UPN): _____*(Compulsory; registration will not be accepted without this item. All treatments (HCT/CT/IST) of the patient must be registered with the same patient identification number or code as this belongs to the patient and not to the treatment.)***Date of birth:** ____/____/____ (YYYY/MM/DD)*(Year of birth is compulsory; month and date are strongly recommended)***Sex (at birth):**☐ Male☐ Female**Initials:** _____ / _____ (first name / family name)



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PATIENT DATA continued

Blood group:

- ☐ A
☐ B
☐ AB
☐ O

Rhesus factor:

- ☐ Negative
☐ Positive

Participation in non-EBMT national/international study/trial:

- ☐ No
☐ Yes: *for every non-EBMT study/trial complete the questions below*

Name of study/trial: _____

Specify details: _____

Number of patients : _____

Can the patient be included in EBMT studies?

☐ No

☐ Yes

APPENDIX

For relevant centres only

Area or postal code where patient was living during the HCT/CT/IST: _____*(Optional; to be used by the centre to register this data if required by the country legislation)***Ethnicity:** *(to be used only by centres from the UK)*

- ☐ White - British
- ☐ White - Irish
- ☐ White - Any other White background
- ☐ Mixed - White and Black Caribbean
- ☐ Mixed - White and Black African
- ☐ Mixed - White and Asian
- ☐ Mixed - Any other mixed background
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - Bangladeshi
- ☐ Asian or Asian British - Any other Asian background
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - African
- ☐ Black or Black British - Any other Black background
- ☐ Other Ethnic Groups - Chinese
- ☐ Other Ethnic Groups - Any other ethnic group
- ☐ Not stated
- ☐ Unknown