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: _____
(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 allogeneic HCT: _____
(Include *all allogeneic HCTs this patient received in the past*)

ALLOGENEIC 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.

DONOR & GRAFT

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 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 4-8)

☐ Yes

Date of birth: _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)*

(year of birth is a mandatory field)

***Age at time of donation:** _____ **years**
(optional)

(Skip if the source of stem cells is cord blood)

***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
☐ Not evaluated
☐ Unknown

***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 5)*

DONOR 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 ☐ Peripheral Blood ☐ Cord Blood ☐ Other; specify: _____
(select only one)

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

☐ No

☐ *Yes:
- ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ CD34+ enrichment
- ☐ Genetic manipulation
- ☐ Other; specify: _____

***Was the graft cryopreserved prior to infusion?**
- ☐ No
- ☐ Yes; ***Date of cryopreservation:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* ☐ Unknown
- ☐ Unknown

DONOR 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 2

If more than one stem cell product , this is the first product collected from this donor.

***Source of stem cells:** ☐ Bone Marrow ☐ Peripheral Blood ☐ Cord Blood ☐ Other; specify: _____
(select only one)

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

☐ No

☐ *Yes:
- ☐ T-cell (CD3+) depletion *(Do not use for "Campath in the bag")*
- ☐ T-cell receptor αβ depletion
- ☐ B-cell depletion (CD19+) by MoAB
- ☐ NK cell depletion by MoAB
- ☐ CD34+ enrichment
- ☐ Genetic manipulation
- ☐ Other; specify: _____

***Was the graft cryopreserved prior to infusion?**
- ☐ No
- ☐ Yes; ***Date of cryopreservation:** _ _ _ _ / _ _ / _ _ *(YYYY/MM/DD)* ☐ Unknown
- ☐ Unknown

DONOR 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?**
(for both matched and mismatched related donors)
- ☐ No
- ☐ Yes
- ☐ Unknown

***HLA match type:**

☐ *Match (both haplotypes matched)

☐ *Mismatch:

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

if molecular typing was done:

*Locus:	*Number of mismatches, allelic:
A:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
B:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
C:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DRB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DQB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DPB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated

if serological typing was done:

*Locus:	*Number of mismatches, antigenic:
A:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
B:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
C:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DRB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DQB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DPB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated

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

DONOR 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:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
B:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
C:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DRB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DQB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DPB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated

if serological typing was done:

***Locus:**	***Number of mismatches, antigenic:**
A:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
B:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
C:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DRB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DQB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ Not evaluated
DPB1:	☐ 0 (match) ☐ 1 ☐ 2 ☐ 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 ☐ B ☐ C ☐ DRB1 ☐ DQB1 ☐ 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 10-11)

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
☐ 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
☐ 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

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
☐ 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: _____

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: _____

GvHD PREVENTIVE TREATMENT

GvHD preventive treatment:

☐ No

☐ Yes: indicate the drugs

☐ Abatacept

☐ Alemtuzumab

☐ Anti-Thymocyte Globulin (ATG) | Anti-Lymphocyte Globulin

Product name: _____ Origin: ☐ Rabbit ☐ Horse ☐ Other; specify: _____

Anti-Thymocyte Globulin (ATG) total cumulative dose (mg/kg): ___ ☐ Unknown

☐ Basiliximab

Corticosteroids:

☐ Beclometasone

☐ Budesonide

☐ Dexamethasone

☐ Methylprednisolone

☐ Prednisolone

☐ Cyclophosphamide Post Transplant Cyclophosphamide (PTCY) cumulative dose (mg/kg): _____ ☐ Unknown

Post Transplant Cyclophosphamide (PTCY) timing schedule: ☐ Single dose on day 3 ☐ Single dose on day 5 ☐ Doses on days 3 and 4 ☐ Doses on days 3 and 5 ☐ Other, specify: _____

☐ Cyclosporine

☐ Etanercept

☐ Everolimus

☐ Infliximab

☐ Methotrexate

☐ Mycophenolate mofetil

☐ Ruxolitinib

☐ Sirolimus

☐ Tacrolimus

☐ 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